

Kevin J. Klos, M.D.



Electromyogram (EMG)
Botox Services
Tremor Analysis
Deep Brain Stimulation
Parkinson's Disease Center

Patient Registration

Patient Name: _____

Date of Birth _____ Social Security #: _____

Sex ____ Age ____ Marital Status ____ Place of Birth _____

Address: _____ City _____ Zip _____

Home Phone: _____ Cell Phone _____

Business Phone: _____

Spouse's Name: _____

I am currently Employed Retired a Student.

Place of Employment: _____

Address: _____

Emergency Contact Name: _____ Relationship to patient: _____

Emergency Contact Phone: _____

Referring Physician: _____

Medicare Number (if applicable) _____

Medicare Primary: Yes No

Primary Insurance Company: _____

Subscriber I.D.# _____ Group # _____

Secondary Insurance Company: _____

Subscriber I.D.# _____ Group # _____

Workman's Compensation: Yes No

The Movement Disorder Clinic of Oklahoma

7302 S. Yale • Tulsa, OK • 74136 • Ph(918) 392-4530 • Fax (918) 392-4535 • www.mdcok.com

MDC

the MOVEMENT
DISORDER CLINIC
of Oklahoma

Please List your Health Care Providers:

Primary Care Physician:

First Name: _____

Last Name: _____

City: _____ State: _____

Other providers to receive communication from Dr. Klos:

Name: _____

City: _____ State: _____

Please List all Pharmacies that you participate with:

Primary Pharmacy Name: _____

City: _____

State: _____

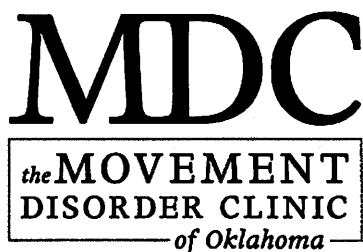
Phone Number (if known): _____

Secondary Pharmacy Name: _____

City: _____

State: _____

Phone Number (if known): _____



Please indicate all Past Medical Conditions:

- | | |
|---|--|
| <input type="checkbox"/> Allergic rhinitis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Atrial fibrillation |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Circulatory system disorder |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Herniated disc |
| <input type="checkbox"/> High blood pressure (hypertension) | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> High lipids | <input type="checkbox"/> Hypothyroid |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Irritable bowel syndrome |
| <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Mitral valve disorder | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Skin disorder |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Visual impairment |
| <input type="checkbox"/> Unknown | |

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Social History:

Do you smoke? Yes No Former

Number of Packs per day? _____

Number of years? _____

Date you Quit? _____

Do you drink alcohol? Yes No

Number of drinks? _____ per _____ (day, month, year)

Have you used drugs? Yes No

Drugs Type: _____

Other habits? _____

Allergies

Fill in the box if you have ever had an allergy or sensitivity to each of the following items:

- | | | |
|--|--|--|
| <input type="checkbox"/> Latex or rubber | <input type="checkbox"/> Betadine or skin disinfectant | <input type="checkbox"/> I have other allergies not listed |
| <input type="checkbox"/> Specific foods | <input type="checkbox"/> Iodine or X-ray contrast dye | <input type="checkbox"/> No allergy to any of these items |
| <input type="checkbox"/> Influenza (flu) vaccination | <input type="checkbox"/> Other vaccines- Tetanus, etc. | |
| <input type="checkbox"/> Adhesive tape | <input type="checkbox"/> Anesthetics | |

3. List all medications, substances, foods, dusts, and animal to which you have an allergy or unpleasant side effect.

List drug or item:	Reaction:	List drug or item:	Reaction:

4. Self-Care/ Home Environment

Can you climb two flights of stairs without stopping to rest? <input type="checkbox"/> Yes, with no difficulty <input type="checkbox"/> Yes, with difficulty <input type="checkbox"/> No, can't do at all <input type="checkbox"/> Don't know
Are you dependent on a device for normal breathing (Nasal oxygen, CPAP)? <input type="checkbox"/> No <input type="checkbox"/> Yes
Are you dependent on a gait-aid device or wheelchair? <input type="checkbox"/> No, I walk independently <input type="checkbox"/> Yes, walker <input type="checkbox"/> Yes, cane <input type="checkbox"/> Yes, wheelchair <input type="checkbox"/> Don't know
Check the box to the left of each activity which you have difficulty performing on your own: <input type="checkbox"/> Preparing meals <input type="checkbox"/> Using toilet <input type="checkbox"/> Bathing <input type="checkbox"/> Getting in and out of bed <input type="checkbox"/> Feeding yourself <input type="checkbox"/> Housekeeping <input type="checkbox"/> Walking <input type="checkbox"/> Managing medications <input type="checkbox"/> Dressing <input type="checkbox"/> Using transportation <input type="checkbox"/> No difficulty with any of these items
Which of the following describes your living environment? <input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Assisted Living <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other
With whom do you live? <input type="checkbox"/> Live alone <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Family <input type="checkbox"/> Other
Do you have assistance for your home care from family, friends, or others should you require it? <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you wear hearing aids? <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have a living will or advance directive? <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have cultural or religious preferences that you feel we should know about during your care? <input type="checkbox"/> No <input type="checkbox"/> Yes

Patient Signature _____ Date: _____

Physician Signature _____ Date: _____

Read and reviewed with patient in detail

Check the appropriate boxes to identify all illnesses or conditions which you know have occurred in you or your blood relatives. Indicate "NONE" if you are unsure.

	Self	Father	Mother	Brothers	Sisters	Sons	Daughters	Grandparents	None
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High or low white count	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational/Street drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Psychiatric disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide (or attempted suicide)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anesthesia complication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genetic disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Signature _____ Date: _____

Physician Signature _____ Date: _____

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PATIENT:

Review of Systems		
<p>Check each box to the left of each symptom which you wish to call to the attention of your health care provider. Select "No Symptoms" if you have not experienced any of the listed symptoms. Select "Other Symptom(s)" if the symptom you wish to report is not listed.</p>		
<input type="checkbox"/> fevers <input type="checkbox"/> enlarged lymph glands <input type="checkbox"/> loss of appetite <input type="checkbox"/> weight gain (>10 pounds) <input type="checkbox"/> weight loss (>10 pounds) <input type="checkbox"/> fatigue <input type="checkbox"/> chest pain <input type="checkbox"/> chest pressure <input type="checkbox"/> awakened with shortness of breath <input type="checkbox"/> cramping pain when walking <input type="checkbox"/> rapid or fluttering heart beats <input type="checkbox"/> coughing up phlegm <input type="checkbox"/> coughing up blood <input type="checkbox"/> coughing <input type="checkbox"/> shortness of breath <input type="checkbox"/> wheezing <input type="checkbox"/> sinus congestion <input type="checkbox"/> joint swelling <input type="checkbox"/> pain or stiffness in joints <input type="checkbox"/> light-headedness <input type="checkbox"/> "blackout spells"	<input type="checkbox"/> difficulty swallowing <input type="checkbox"/> heartburn <input type="checkbox"/> nausea and / or vomiting <input type="checkbox"/> constipation <input type="checkbox"/> diarrhea <input type="checkbox"/> changes in stool <input type="checkbox"/> abdominal pain or cramping <input type="checkbox"/> frequent urination <input type="checkbox"/> burning or painful urination <input type="checkbox"/> uncontrolled urge to urinate <input type="checkbox"/> blood in urine <input type="checkbox"/> leaking urine <input type="checkbox"/> nipple discharge <input type="checkbox"/> breast lump <input type="checkbox"/> skin rash / skin sores <input type="checkbox"/> change in mole or skin spot <input type="checkbox"/> unusual bruising <input type="checkbox"/> change in sexual drive / performance <input type="checkbox"/> unusual thirst <input type="checkbox"/> vision problems <input type="checkbox"/> hearing loss	<input type="checkbox"/> headaches <input type="checkbox"/> seizures <input type="checkbox"/> slurred speech <input type="checkbox"/> hoarseness <input type="checkbox"/> double vision <input type="checkbox"/> back pain / stiffness <input type="checkbox"/> weakness in arms or legs <input type="checkbox"/> numbness or shooting pain <input type="checkbox"/> tendency to fall asleep <input type="checkbox"/> muscle pain / stiffness <input type="checkbox"/> heavy snoring <input type="checkbox"/> irregular breathing in sleep <input type="checkbox"/> excessive daytime drowsiness <input type="checkbox"/> sleep difficulty <input type="checkbox"/> feel sad most of the time <input type="checkbox"/> feel anxious or nervous <input type="checkbox"/> feel restless or irritable <input type="checkbox"/> recurring thoughts of death or suicide <input type="checkbox"/> little interest in relationships or activities <input type="checkbox"/> difficulty concentrating <input type="checkbox"/> other symptom(s) not listed <input type="checkbox"/> No symptoms

Other questions or concerns: _____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

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