UCLA Health System

UCLA NEUROLOGY CLINIC
300 MEDICAL PLAZA, SUITE B200
BOX 956975
LOS ANGELES, CA 90095-6975

Welcome to the UCLA Neurology Clinic!

The UCLA Westwood Neurology Clinic is a highly integrated department of neurologists with sub-specialization in the evaluation, and treatment of disorders affecting the nervous system. The Clinic offers state-of-the-art expert consultative, diagnostic and therapeutic services for a full range of neurological conditions such as Cognitive Disorders, Epilepsy, Movement Disorders, Multiple Sclerosis, Neurogenetics, Neurorehabilitation, Neuromuscular Disorders, Neuro-Oncology, Neuro-Otology, Sleep Disorders, and Stroke.

Our department has earned outstanding reputation in subspecialty care of neurological disorders due to a high level of clinical expertise, academic achievement and innovative research. Our most important mission is to provide each patient with the best neurological health care available by combining our extensive experience with the latest advances in neurology. Our faculty and staff work together as a team to bring each patient the highest quality of care in a warm, friendly and professional environment.

Further information about our clinics can be found online by logging to the UCLA Neurology Home Page: http://www.neurology.ucla.edu/ and navigating to the “Clinical” site.

We look forward to seeing you here.

Alon Y. Avidan, MD, MPH
Medical Director, UCLA Neurology Clinic

Bindu Rudramurthy
Director of Clinical Operations, Neurology

UCLA Neurology Clinic:
300 UCLA Medical Plaza, Suite B200
Box 956975
Los Angeles, CA 90095-6975

Website: http://www.neurology.ucla.edu/ (CLINICAL)
Phone: 310-794-1195
Fax: 310-794-7491
Medical Records: 310-825-6021

Welcome to the UCLA Neurological Services Clinic in the 300 Medical Plaza. To serve you best, we would like to tell you about our services.

UCLA Health System

GENERAL NEUROLOGY CLINIC QUESTIONNAIRE

UCLA Department of Neurology

Many people have managed health care coverage from health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Coverage and benefits vary widely. In most health care plans, to see physicians trained in a certain area of medicine such as neurology, your visit and any recommended tests from our doctors must be authorized by your primary care doctor's medical group and your health plan in advance. You should have obtained a written authorization from your health plan **prior** to making your appointment. Be sure to bring the authorization statement with you to your appointment. If you are a Medicare member, you may have different coverage or requirements.

We ask that you kindly familiarize yourself with your specific insurance benefits. Often you will be asked to pay fees from $5 up to $50 (known as a co-payment) upon arrival. You may find information on whether you are required to pay a copayment by reviewing your heath plan booklet and your membership card.

If you do not have a written authorization for the visit or if your health membership card, or if you do not have health insurance, the cost for the first visit ranges from $380 to $690. Payment by cash, check or credit card is expected at the end of the visit.

Enclosed, please find the followings:

- ☑ Your appointment confirmation,
- ☑ Map to the UCLA Neurology Clinic
- ☑ Patient Questionnaire to be completed **PRIOR** to your appointment and to be turned in to the receptionist upon arrival to our clinic.

Please plan to arrive at least 20 minutes prior to your appointment. You may be rescheduled if you are more than 20 minutes late for your new visit

In order for us to serve you best, please remember to:

- ☑ Bring your medical insurance eligibility card
- ☑ Insurance claim forms (copayment and authorization documents)
- ☑ Pertinent medical records (Imaging, MRI, CT, EEG, EMG, sleep Studies and blood work).
- ☑ Names, complete addresses and telephone number of your referring physicians
- ☑ Completed patient questionnaire.

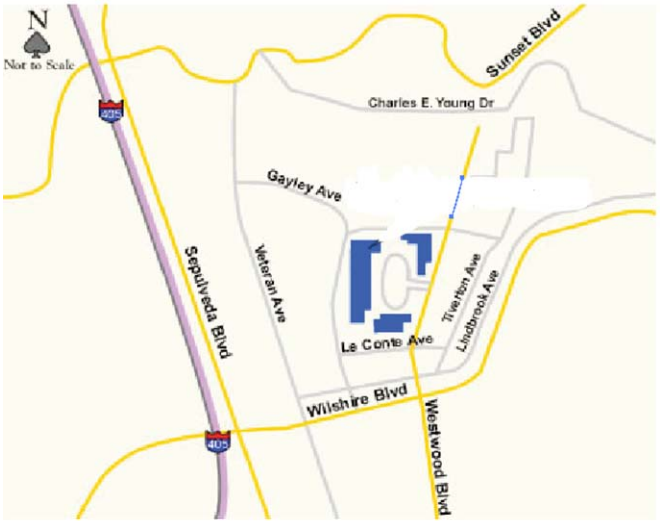
You MUST call us at least 72 hours in advance if you need to change your appointment.

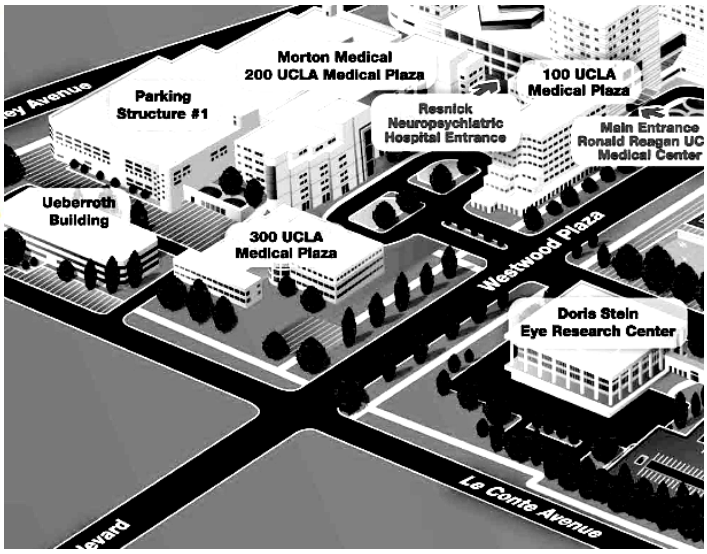
- ✷ If you fail to notify us of cancellation within 72 hours, you may be subjected to a $50 cancellation fee.
- ✷ If you have any questions or need to reschedule your appointment, please call **(310) 794-1195.**

DIRECTIONS TO THE UCLA NEUROLOGY CLINIC AT 300 UCLA MEDICAL PLAZA:

Your appointment is in **300 Medical Plaza** about ½ block north of the intersection of Westwood Boulevard and Le Conte Ave.

- From 405 North, exit Wilshire Blvd., **Westwood**.
- From 405 South, exit Wilshire Blvd., **East**.
- From Wilshire Blvd heading East, turn left (north) on Westwood Blvd.
- Proceed 4 blocks and cross Le Conte Ave.
- Turn left at the first signal light into the Medical Plaza driveway & proceed to Visitor Parking (See Parking instructions below).
  - ⇒ Proceed to **300 Medical Plaza (Three story Building with Clock). The Neurology Clinic is located in the "B 1" (Basement Level) Suite 200.**





PARKING

Follow the one-way circular driveway. Take the ramp into underground parking on your left side. Proceed to the parking area for 200 & 300 UCLA Medical Plaza. The parking fee is $11 per car entry. Handicapped parking is available at the underground entrance of 300 Medical Plaza. There is a $3.00 parking charge for visitors displaying valid handicapped plates or placards.

PATIENT DROP-OFF AREAS LOCATIONS OF CLINIC

A drop-off area is located in front of the 300 Medical Plaza (Building with clock) on the circular driveway at the street level. Take the elevator to level B 1. In the underground parking structure, you will enter on level B 1.

Follow the sign to Neurological Services, Suite B200.

UCLA Health System

GENERAL NEUROLOGY CLINIC QUESTIONNAIRE

UCLA Department of Neurology

PATIENT INFORMATION

Last, First, Middle Name			Today's Date
Age	Birth Date	Sex:	Native Language:
		Male / Female	
Referring Physician's Full Name			Telephone #:
Physician's Address			
Are you:	Right-handed	Left-handed	Ambidextrous
Why do you need to see a Neurology specialist?			

Past Medical History	Date Diagnosed

Hospitalizations, Operations and dates

Injuries and dates. Include any episodes of loss of consciousness.

Blood Transfusions and dates

Drug Allergies and reactions:

UCLA Health System

GENERAL NEUROLOGY CLINIC QUESTIONNAIRE
UCLA Department of Neurology

Medications (current and/or recent)

Name	Dosage	How often?

(*Attached typed sheet/write on back if necessary)

Dietary Supplements/Vitamins:

Name	Dose & Frequency

Social History

Any use of tobacco (type and for how long)? _____

_____

Any use of alcohol (type and for how long)? _____

Any use of recreational drugs (type and for how long)? _____

Any exposure to toxins/poisonous substances at work or with hobbies? _____

_____

What type of work do you do? _____

Education: Grade School High School College Post-Graduate Voc. Training

Marital Status: Single Married Divorced Separated Widowed

Birthplace: _____

_____

UCLA Health System

GENERAL NEUROLOGY CLINIC QUESTIONNAIRE
UCLA Department of Neurology

FAMILY HISTORY

Mother: Living or deceased? Age: _____
Health Problems: _____

Father: Living or deceased? Age: _____
Health Problems: _____

Brothers/Sisters: List from the oldest to youngest.

1. Brother or sister? Living or deceased? Age: _____
Health problems: _____

2. Brother or sister? Living or deceased? Age: _____
Health problems: _____

3. Brother or sister? Living or deceased? Age: _____
Health problems: _____

4. Brother or sister? Living or deceased? Age: _____
Health problems: _____

Children: List from oldest to youngest.

1. Daughter or son? Living or deceased? Age: _____
Health problems: _____

2. Daughter or son? Living or deceased? Age: _____
Health problems: _____

3. Daughter or son? Living or deceased? Age: _____
Health problems: _____

Have any of your family or relative had the following health conditions? If yes, whom?

Heart disease	_____	Stroke	_____
High blood pressure	_____	Fainting	_____
High cholesterol	_____	Diabetes	_____
Loss of memory	_____	Cancer	_____
Epilepsy/seizures	_____	Multiple sclerosis	_____
Depression	_____	Polio	_____
Mental disease	_____	Limping	_____
Muscle weakness	_____	Thyroid disease	_____

Other: _____

THANK YOU VERY MUCH FOR COMPLETING EHIS QUESTIONNAIRE. BE SURE TO BRING IT TO YOUR DOCTOR'S APPOINTMENT

UCLA Health System

GENERAL NEUROLOGY CLINIC QUESTIONNAIRE

UCLA Department of Neurology

REVIEW SYSTEMS

Please place a checkmark if you currently have any of the following symptoms. (Disregard the bold headings in quotes on the left. They are for administrative purposes only).

1.	"constitutional"	☐ fever	☐ weight loss	☐ fatigue
2.	"eyes problem"	☐ blurred vision ☐ eye pain	☐ double vision ☐ eye redness	☐ loss of vision ☐ eye dryness
3.	"ear/nose/throat"	☐ trouble hearing ☐ loss of balance ☐ hoarseness	☐ ringing in ear(s) ☐ ear pain ☐ trouble swallowing	☐ dizziness (vertigo) ☐ ear discharge ☐ slurred speech
4	"cardiovascular"	☐ chest pain ☐ limb swelling	☐ Irregular heart beat ☐ limb pain on walking	☐ fast heart beat ☐ fainting
5.	"respiratory"	☐ trouble breathing	☐ chronic cough	☐ coughing blood
6.	"gastrointestinal"	☐ indigestion ☐ nausea ☐ diarrhea	☐ heart burn ☐ vomiting ☐ constipation	☐ abdominal pain ☐ regurgitation ☐ bloody stools
7.	"genitourinary"	☐ incontinence	☐ pain on urination	☐ blood in urine
8.	"musculoskeletal"	☐ muscle pain ☐ loss of muscle bulk ☐ joint pain	☐ muscle cramp ☐ neck pain ☐ joint stiffness	☐ muscle twitches ☐ back pain ☐ joint swelling
9.	"skin & breast"	☐ numbness	☐ tingling	☐ discoloration
10.	"neurologic"	☐ headache ☐ weakness ☐ blackouts	☐ face pain ☐ tremors ☐ trouble with memory	☐ face numbness ☐ clumsiness ☐ trouble concentrating
11.	"psychiatric"	☐ hallucinations ☐ suicidal thoughts	☐ feeling depressed ☐ Inappropriate crying	☐ trouble sleeping ☐ inappropriate laughing
12.	"hematologic/lymphatic"	☐ abnormal bleeding	☐ nose bleeds	☐ lumps or swellings
13.	"allergic/Immunologic"	☐ skin rash	☐ Joint pain	☐ dry eyes & or dry mouth
14.	"endocrine"	☐ excessive thirst	☐ heat or cold intolerance	☐ excessive urination

Person completing questionnaire _____ Relationship to patient _____

For office use: This questionnaire may be completed by the patient, relative or ancillary staff provided that it is signed and dated by the treating physician. (Reference may later be made to this information by a signed and dated statement by the treating physician, designating location of the information, date obtained and any subsequent charges.)

Physician's signature: _____ Date: _____ Time: _____