

CLINICAL NEUROSCIENCES OF TAMPA BAY, LLP (CNS)

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New Patient Information Questionnaire- 2 pages Today's Date _____

Name _____ M F DOB _____ Age ____ SS# _____

Address: _____ Phone(am) _____ (pm) _____

City, State, Zip _____ Race _____ Ht _____ Wt _____

Referring Doctor _____ Primary Doctor _____ Handed: R L

PERMISSION for results of my evaluation to be discussed with or contact for emergency:

Name _____ Phone _____ Relationship _____ Patient Initials: _____

HISTORY OF PRESENT ILLNESS (Chief complaint: Describe your main problem) SYMPTOMS?

	<p align="center">PHYSICIAN'S NOTES:</p>
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PAST MEDICAL HISTORY:** • asthma • arthritis • diabetes • high BP • heart disease • angina • ↑cholesterol
 • kidney • lung disease • hiatal hernia • ulcer • colon or GI • IBS • epilepsy/seizure • stroke • thyroid • skin
 • migraine • other headaches • fibromyalgia • multiple sclerosis • neuropathy • muscle disease • Parkinsons
 • essential tremor, • cancer (type?) _____ • anxiety • depression • other (list): **None of these**

OPERATIONS & HOSPITALIZATIONS	Date	OPERATIONS & HOSPITALIZATIONS	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OVER to page 2 →

Current Medications- Dosage/Frequency (include OTC's) (Or Provide List)

Notes

Please list other medications or treatments previously tried for your neurologic problem.

Medicine (dose & freq) or Treatment

ALLERGIC TO MEDICATIONS? (Y N) List: _____

FAMILY HISTORY: Asthma, Arthritis, Alcoholism, Parkinsons, Colon, Skin, • Diabetes
 • High BP • Heart disease, • Angina, • Kidney, • Lung, • Stroke, • Cancer (type?) _____
 • Muscle Disease, • Neuropathy, • Tremor, • Epilepsy/Seizure, • Multiple sclerosis , • Migraine, • Other

SOCIAL HISTORY

Marital Status: S M D W Children # _____ Education/Degree/yr _____ Occupation _____ Retired: • Yes
 Smoking: (Y N Quit) Pack/day _____ Years _____ Quit _____ • Assisted Living • Nursing Home
 Alcohol (no rare social daily) drinks/wk _____ Current/Past Problem: Alcohol (Y N) Drug (Y N)

REVIEW OF SYMPTOMS

- GENERAL Weight • gain or • loss of _____ lbs • fever • fatigue • sleep problem
- EYE • decreased vision R L • double vision • eye pain • _____
- ENT • sinus • post nasal drip • swallowing problems • hearing loss
 • ringing in ears • dizziness • TMJ problem • _____
- RESP • shortness of breath • cough • congestion • wheezing • _____
- CV • chest pain • palpitation • edema • fainting • _____
- GI • nausea • diarrhea • cramps • abdominal pain • _____
- GU • loss of bladder control/wetting yourself • trouble voiding • sexual problem
- GYN • new pregnancy • menstrual problems • started hormones • breast problem
- MUS-SKEL • joint pains • neck pain • back pain • muscle cramps • _____
- SKIN • rash • itching • hair loss • hair growth • _____
- NEURO • memory difficulty • numbness • headache • loss of coordination • tingling
 • double vision • slurred speech • seizure • speaking • weakness
- PSYCH • nervous • anxiety • depressed • confusion • seeing psychiatrist • bipolar • suicidal thoughts
- ENDO • diabetes • hypoglycemia • low/high thyroid • _____
- HEME • low blood count • swollen glands • _____
- ALLERGY • asthma • frequent or unusual infections • HIV or AIDS • _____

I have read and agree to the HIPAA consent and allow CNTB to release my medical records to my Insurance Carriers, referring Physicians and Morton Plant Neuroscience Clinics (if I am a patient). I hereby understand the financial office policy of this office. I guarantee payment of all charges incurred. I authorize release of medical records, labs, and Radiology reports from outside sources to CNTB. *CNTB DOES NOT SEE ACCIDENT CASES AS AUTO, WORKMANS COMP, OR SLIP AND FALLS; if accident care is a current or future problem I will treat with other physicians.**

Signature _____
Date
Pharmacy name and phone number _____