

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: _____

***Please bring to your next appointment any previous testing reports, films and/or disks ex: MRI, CT, Labs etc.**

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

<p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>5. _____</p>	<p>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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Medications- Dosage/Frequency (include OTC's) _____ (Or Provide List) **OVER to page 2 →** 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/yrs _____ 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) and to obtain and release e-medical history from/to pharmacies and physicians.

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