

**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><b>PHYSICIAN'S NOTES:</b></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