

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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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