CLINICAL NEUROSCIENCES OF TAMPA BAY, LLC (CNS)
430 Morton Plant St. Suite 400 – Clearwater, Florida 33756
(727) 443-3295 – Fax (727) 446-4336
Robert Vollbracht MD, Diana L. Pollock MD, Ajay Arora MD,
Jean-Raphael Schneider MD, Daniel Cabello MD

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?

	PHYSICIAN'S NOTES:
1.	
2.	
3.	
4.	
5.	
6.	

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, Alchoholism, 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 _________

ACCIDENT Slip/Fall MVA Driver Passenger Car hit: Front Back/Rear End T-boned Date ___________
(if applicable) Head-on Treated Hospital/ER Hit head Blackout dizzy Aggravated a previous problem
Pre-existing or similar problems? Previous Accident Date___________ Residuals: Yes No

I have read and agree to the HIPAA consent and allow CNS 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 CNS.

____ ____________________

Signature **Date**