CLINICAL NEUROSCIENCES OF TAMPA BAY, LLP (CNTB)
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?

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

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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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: (M=Mom F=Father D=daughter S=Son Sis=Sister B=Brother)

Asthma, Arthritis, Alchoholism Parkinsons Colon/IBS, Skin Diabetes Dementia/or/Alzheimer's

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). 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, Workman's comp or Slip and Fall; if accident care is a current or future problem I will treat with other physicians. I allow CNTB to obtain and release E-Med history from/to pharmacies and physicians.

_____ _____

Signature **Date**

Pharmacy_____