CLINICAL NEUROSCIENCES OF TAMPA BAY, LLP (CNTB)
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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: _____

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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	**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: (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_____