

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,
Daniel Cabello MD, Ashima Bahl, ARNP

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?

<p>1.</p> <p>2.</p> <p>3.</p> <p>4.</p> <p>5.</p> <p>6.</p>	<p>PHYSICIAN'S NOTES:</p>
---	---------------------------

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