

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?

<p>1.</p> <p>2.</p> <p>3.</p> <p>4.</p> <p>5.</p> <p>6.</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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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, Alcoholism 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