

NEW PATIENT INFORMATION

Tallahassee Neurological Clinic – Department of Neurology

Today's Date _____ Have you ever been seen in this office before today's visit? _____

Patient Name _____ Date of Birth _____

Address _____ City/State/Zip _____

Soc. Sec. # _____ Marital Status _____ Gender _____

Preferred Language _____ Race _____ email _____

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Other or Undetermined

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Name of Referring Physician/Agency _____

Name of PCP or Family Physician _____

Responsible Party Self Spouse Parent Other

Responsible Party Name _____ Phone _____

Date of Birth _____ SS# _____

In Case of Emergency, please notify _____

Address _____ Relationship _____ Phone _____

Insurance Information

Reason for today's visit Illness Auto Accident Job Injury Other Injury

Date of Accident _____ **Date of Injury** _____

1. **Worker's Compensation Co. Name** _____

Claim # _____ Adjustor's Name & Phone Number _____

Auto Insurance Name _____ Policy/Claim Number _____

2. Primary Health Ins. Co. _____

Insured's Name _____ DOB _____ Soc. Sec. # _____

Relationship to Patient Self Spouse Parent Other

Policy # _____ Group # _____

3. Secondary Health Ins. Co. _____

Insured's Name _____ DOB _____ Soc. Sec. # _____

Relationship to Patient Self Spouse Parent Other

Policy # _____ Group # _____

I have completed this form entirely and certify that I am the patient or duly authorized agent of the patient to furnish the information requested. I understand that even though I may have insurance coverage, I am ultimately responsible for payment of services rendered.

Patient/Resp Party Signature _____ **Date** _____

Tallahassee Neurological Clinic

Department of Neurology

History Intake Form

Date: _____ TNC Neurologist: _____

Patient Name _____ DOB _____

Family Doctor _____

What is the primary reason you are coming to see the doctor? _____

Please describe your problem, including the onset, symptoms, and duration _____

SPINAL INJURIES

Have you ever had an injury to your back or neck? If so, please describe _____

PAST SURGICAL HISTORY

Please list all of your previous surgeries, including minor surgeries, along with the year and surgeon who did the operation

1. _____

2. _____

3. _____

4. _____

5. _____

PAST MEDICAL HISTORY

Please list all your medical problems, including such things as heart, lung and kidney problems and medical problems such as diabetes, cancer, high blood pressure, etc.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

MEDICATIONS

Please list all medications you are taking, including over-the-counter medicines such as aspirin, etc., along with the dose and frequency of medication. **(Bring medicine bottles to appointment)**

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |

ALLERGIES

Please list all allergies to medications and the reaction you have with the medicine

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

SOCIAL HISTORY

Right or Left Handed _____

How many children do you have? _____ Are they healthy? _____

If not healthy, what diseases do they suffer? _____

Have you ever or do you now smoke? _____ If so, how long and how much? _____

If you were a previous smoker, when did you stop and how long did you smoke? _____

Do you drink alcohol? _____ If so, how much and how frequently? _____

If you drank alcohol previously, when did you stop and how long did you drink? _____

Do you now or have you ever used illegal drugs? _____

FAMILY HISTORY

Is your mother alive? _____ If not, of what and at what age did she die? _____

Is your father alive? _____ If not, of what and at what age did he die? _____

How many brothers? _____ and sisters _____ do you have?

Please list their medical problems _____

Has anyone in your family suffered cancer or a neurological disease? Please list: _____

REVIEW OF SYMPTOMS

Please circle all that apply to you or that you notice

General	Recent weight loss, recent weight gain, weakness, fatigue, fever
Skin	Rashes, lumps, sores, itching, dryness, changes in nails, changes in hair
Head	Headache, head injury
Eyes	Visual loss, pain, redness, double vision, excessive tearing
Ears	Hearing loss, ringing in ears, earaches, ear infections, drainage from ears
Nose & Sinuses	Nasal stuffiness, nasal discharge, nosebleeds
Mouth & Throat	Bleeding gums, loss of teeth, sore tongue, sore throat, sores on gums, sores inside mouth
Neck	Lumps in neck, "swollen glands", goiter
Breasts	Lumps, pain or discomfort, nipple discharge
Respiratory	Cough, coughing up blood, wheezing, asthma, bronchitis
Cardiac	Heart trouble, heart murmurs, chest pain, palpitations, rheumatic fever
Gastrointestinal	Swallowing troubles, heartburn, nausea, vomiting, vomiting of blood, change in bowel habits, rectal bleeding, abdominal pain, liver troubles
Urinary	Frequent urination, burning with urination, incontinence, stones, infection
Peripheral Vascular	Leg cramps, varicose veins, clots in legs
Neurological	Fainting blackouts, seizures, tremors, involuntary movements, strokes
Hematological	Anemia, easy bruising, excessive bleeding, transfusion reactions in past
Endocrine	Thyroid trouble, excessive sweating, diabetes, excess thirst, excess hunger
Psychiatric	Nervousness, tension, depression, any history of psychiatric problems

Please do not write below this line

BP _____ Pulse _____ Resp _____ Temp _____ Weight _____

Physician Signature _____ Date _____