UFHealth | NORMAN FIXEL CENTER FOR NEUROLOGICAL DISEASES

Movement Disorders & Neurorestoration Program

New Patient Information Form

This form will help the doctor obtain information relevant to your care. Please fill out **all sides** as best you can.

Legal Name: _____

Preferred Name: _____

Medical Record #: _____ Date: _____

Referring Physician: _____ *Our doctors will send a report to your referring physician. Please indicate if you want a copy sent to someone else:*

☐ Other Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

☐ Yourself

☐ Other: _____

Please state the main reason for this visit on the line below. Just state your main symptom(s) or concerns; for example, "headache" or "trouble walking." Do not include details of your history or testing. You will have ample opportunity to give the doctor the complete story. On the reverse side of this form, you can check off specific symptoms.

_____

Medical History: Please check any diseases that you have had in the past or have now and the year of onset:

Disorder	*Onset*	*Disorder*	*Onset*	*Disorder*	*Onset*	*Disorder*	*Onset*
☐ Heart Disease		☐ High Blood pres.		☐ Lung disease		☐ Thyroid disease	
☐ Atrial Fibrillation		☐ High cholesterol		☐ Asthma		☐ Migraine	
☐ Blood clots		☐ Diabetes		☐ Kidney failure		☐ Sleep disorder	
☐ Stroke		On insulin? Yes No		Trauma		☐ Miscarriages	
☐ Epilepsy		☐ Cancer		☐ Head		☐ Reflux (GERD)	
☐ Liver disease		*Location*	*Year*	☐ Neck		☐ Fibromyalgia	
☐ Depression				☐ Other		☐ ADD/ADHD	
		☐ Anxiety		☐ OCD			

Other Medical History: _____

Surgical History: Please check surgeries you have had and indicate year:

Surgery	Date	Surgery	Date	Surgery	Date	Surgery	Date
☐ Heart		☐ Colon polyp		☐ GI bypass/stapling (bariatric surg.)		☐ Hip replacement	
☐ Bypass graft		☐ C-section		☐ Hernia		☐ Knee replacement	
☐ Stent		☐ Gall bladder		☐ Vasectomy		☐ Cataract	
☐ Cancer *(fill in type)*		☐ Breast lump		☐ Bladder		*Other surgeries:*	
☐ _____		☐ Appendix		☐ Brain		☐ _____	
☐ _____		☐ Tonsils		☐ Neck		☐ _____	
☐ _____		☐ Hysterectomy				☐ _____	

Family History: For each of the disorders listed below, indicate in the column titled "Rel" which family member(s) had the illness, using the abbreviations listed.

Relationship Abbreviations:	
M	Mother
F	Father
B	Brother
S	Sister
C	Child
GP	Grandparent
O	Other

Rel.	**Disease**	**Rel.**	**Disease**	**Rel.**	**Disease**
	ADD/ADHD		Heart Disease		Substance Abuse
	Alzheimer's		High Blood Pressure		Tremors
	Cancer		Muscle Problem		Tics/Tourette
	Depression		Neuropathy		
	Dementia		OCD		
	Diabetes		Parkinson's		
	Dystonia		Stroke		

(Continue on the following page)

Review of Systems: *Please indicate if you are CURRENTLY experiencing any of the following conditions:*

Constitutional	Yes	No	Eyes	Yes	No	Gastrointestinal	Yes	No	Endo/Heme	Yes	No
Fever	☐	☐	Blurred Vision	☐	☐	Heartburn	☐	☐	Easy to Bruise	☐	☐
Chills	☐	☐	Double Vision	☐	☐	Nausea	☐	☐	Seasonal Allergies	☐	☐
Weight Loss	☐	☐	Sensitive to Light	☐	☐	Vomiting	☐	☐	Excessive Thirst	☐	☐
Fatigue	☐	☐	Eye Pain	☐	☐	Stomach Pain	☐	☐			
Profuse Sweating	☐	☐	Eye Discharge	☐	☐	Diarrhea	☐	☐	**Neurological**	Yes	No
Weakness	☐	☐	Eye Redness	☐	☐	Constipation	☐	☐	Dizziness	☐	☐
						Blood in stool	☐	☐	Tingling	☐	☐
						Dark Tarry Stools	☐	☐	Tremors	☐	☐
									Change in touch	☐	☐
									Speech change	☐	☐
Skin	Yes	No	**Cardiovascular**	Yes	No	**Genitourinary**	Yes	No	Weakness	☐	☐
Rash	☐	☐	Chest pain	☐	☐	Painful Urination	☐	☐	Seizures	☐	☐
Itching	☐	☐	Pounding Heart	☐	☐	Urgency	☐	☐	Loss of Consciousness	☐	☐
			Shortness of breath	☐	☐	Frequency	☐	☐	Involuntary Mvmts	☐	☐
			Leg Swelling	☐	☐	Blood in Urine	☐	☐	Poor Concentration	☐	☐
						Side Pain	☐	☐	Restless Legs	☐	☐
Head/ENT	Yes	No	**Respiratory**	Yes	No	**Musculoskeletal**	Yes	No	**Psychiatric**	Yes	No
Headaches	☐	☐	Cough	☐	☐	Muscle Pain	☐	☐	Depression	☐	☐
Hearing Loss	☐	☐	Coughing up Blood	☐	☐	Neck Pain	☐	☐	Suicidal Ideas	☐	☐
Ringing in ears	☐	☐	Phlegm Production	☐	☐	Back Pain	☐	☐	Substance Abuse	☐	☐
Ear Pain	☐	☐	Shortness of Breath	☐	☐	Joint Pain	☐	☐	Hallucinations	☐	☐
Ear Discharge	☐	☐	Wheezing	☐	☐	Falls	☐	☐	Nervous/Anxious	☐	☐
Nose Bleeds	☐	☐				Cramps	☐	☐	Sleeping Disorder	☐	☐
Loss of Smell	☐	☐							Memory Loss	☐	☐
Congestion	☐	☐									
Wheezing	☐	☐									
Sore Throat	☐	☐									

Social History: *In an effort to better understand the population we serve, we are collecting information about your social situation such as education, gender, sexual orientation. Please answer these questions to the best of your abilities.*

What sex were you assigned on your original birth certificate?

☐ Male
☐ Female
☐ Prefer not to say

Legal sex (as listed on health insurance)

☐ Male
☐ Female
☐ Other: _____

What is your current gender identity?

☐ Female
☐ Male
☐ Transgender female/ Transwoman/Male-to-Female (MTF)
☐ Transgender male/Transman/Female-to-Male (FTM)
☐ Gender nonconforming
☐ Prefer not to disclose
☐ Other: _____

Do you think of yourself as?

☐ Straight or heterosexual
☐ Lesbian, gay, or homosexual
☐ Bisexual
☐ Prefer not to disclose
☐ Don't know
☐ Other: _____

Which pronouns you prefer to be used when addressing you?

☐ She/her/hers
☐ He/him/his
☐ They/them/theirs
☐ Prefer not to disclose
☐ Other: _____

Have you had surgeries to align your body and organs with your gender identity?

☐ Yes
☐ No
☐ Prefer not to disclose

(Continue on the following page)

Currently, you are
- ☐ Partnered
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Other: _____

You live with
- ☐ Alone
- ☐ Partner or spouse
- ☐ Other: _____

You live at
- ☐ Home
- ☐ Relative's home
- ☐ Assisted living facility
- ☐ Nursing home
- ☐ Shelter
- ☐ Other: _____

Current or most recent occupation:
_____

Are you retired?
- ☐ Yes, year _____
- ☐ No

What is the reason for retirement?
_____

Are you disabled or on medical leave?

- ☐ Yes

- ☐ No

Education completed
- ☐ Grade school
- ☐ High school/GED
- ☐ Some college
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ PhD and above

Alcohol use information
- ☐ Never
- ☐ Quit, year _____
- ☐ Yes, how many drinks a week: _____

Tobacco smoking information
- ☐ Never smoked
- ☐ Quit smoking in _____, previously smoked _____ packs/day for _____ years
- ☐ Current smoker, _____ packs/day for _____ years

Tobacco chewing information
- ☐ Never
- ☐ Quit, year _____
- ☐ Current

Marijuana (cannabis) use information
- ☐ Never
- ☐ Quit, year _____
- ☐ Medical marijuana only
- ☐ Current use

Other drug use information (for example, cocaine, heroin, meth, mushrooms, etc…)
- ☐ Never
- ☐ Quit, year _____
- ☐ Current

(Continue to Medication Questionnaire form)

UF UNIVERSITY of FLORIDA
The Foundation for the Gator Nation

UFHealth | NORMAN FIXEL CENTER FOR NEUROLOGICAL DISEASES
Movement Disorders & Neurorestoration Program

Fixel Center for Neurological Diseases at UF Health
Movement Disorders & Neurorestoration Program
3009 SW Williston Rd
Gainesville, FL 32608

Department of Neurology
(352) 294-5400
Fax: (352) 627-4867

Medication Questionnaire for New Patients

Have you taken any of these medications? If so, please list the dose and frequency.

If you have stopped taking the medication for any reason, please tell us why

Sinemet (Carbidopa/Levodopa) Strength (mg):____10/100 ___25/100 _____25/250

_____Still Taking_____Stopped # of doses per day:_____# of tablets per dose: _____

If stopped, why? _____

Sinemet CR (Carbidopa/Levodopa Controlled Release) Strength (mg):_____25/100 _____50/200

____ Still Taking_____Stopped # of doses per day:_____ # of tablets per dose: _____

If stopped, why? _____

Rytary (Carbidopa/Levodopa Extended Release) Strength (mg):_____23.75/95_____36.25/145_____48.75/195_____61.25/245

IPX066

____ Still Taking_____Stopped # of doses per day:_____ # of tablets per dose: _____

If stopped, why? _____

Stalevo Strength (mg):_____50mg _____100mg _____150mg_____200mg

____ Still Taking_____Stopped # of doses per day:_____ # of tablets per dose: _____

If stopped, why? _____

Eldepryl (selegiline) Strength (mg): 5mg

____ Still Taking Stopped # of doses per day:_____# of tablets per dose: _____ If

stopped, why? _____

Azilect (rasagiline) Strength (mg): 0.5mg 1.0mg

____ Still Taking Stopped # of doses per day:_____# of tablets per dose: _____

If stopped, why? _____

Parcopa Strength (mg): _____25/100_____25/250

_____Still Taking_____Stopped # of doses per day:_____# of tablets per dose: _____

If stopped, why? _____

Form Continues on Back

Mirapex (pramipexole) Strength (mg):____0.125mg_____0.25mg_____0.5mg_____1.0mg____1.5mg

____ Still Taking_____Stopped # of doses per day:_____ # of tablets per dose: _____

If stopped, why? _____

Neupro (rotigotine) Strength (mg):____2mg ____4mg _____6mg _____8mg

____Still Taking_____Stopped # of doses per day:_____# of tablets per dose: _____

If stopped, why? _____

Apokyn (apomorphine) Strength (mg):_____10mg/ml

____ Still Taking_____Stopped # of doses per day:_____ # of tablets per dose: _____

If stopped, why? _____

Requip (ropinirole) Strength (mg):____0.25mg____0.5mg_____1mg____2mg____3mg____4mg____5mg

____ Still Taking_____Stopped # of doses per day:_____ # of tablets per dose: _____

If stopped, why? _____

Artane (trihexyphenidyl) Strength (mg):____2.0mg ____5.0mg

____ Still Taking_____Stopped # of doses per day:_____ # of tablets per dose: _____

If stopped, why? _____

Comtan (entacapone) Strength (mg): _____ 200mg

____ Still Taking_____Stopped # of doses per day:_____ # of tablets per dose: _____

If stopped, why? _____

Congentin (benztropine) Strength (mg): _____

____ Still Taking_____Stopped # of doses per day:_____ # of tablets per dose: _____

If stopped, why? _____

Tasmar (tolcapone) Strength (mg):____100mg ____200mg

____ Still Taking_____Stopped # of doses per day:_____ # of tablets per dose: _____

If stopped, why? _____

Symmetrel (amantadine) Strength (mg):____100mg

____ Still Taking_____Stopped # of doses per day:_____ # of tablets per dose: _____

If stopped, why? _____

NEW PATIENT INTRODUCTORY QUESTIONNAIRE

Name:	**Today's Date:**	**Medical Record #:**	**Age:**	**Sex:** ( ) male ( ) female

Referring provider:	**Primary care provider:**

Other specialists you see:

Dominant Hand ( ) Right ( ) Left	**Race/ethnicity**	**Current or most recent occupation:**	**Best contact phone number:**

Reason for referral:

Past or current medical conditions/issues:	**Past Surgeries** (please include approximate dates, location, and surgeon):

Current medications and dosages (or attach separate list):	**Over-the-counter medications:** **Herbs, vitamins, and supplements:** **Birth Control:**

DIABETES SCREEN

Do you have a history of diabetes? ( ) yes ( ) no If yes, do you take insulin for this? ( ) yes ( ) no	If yes, when was this diagnosed? _____
If yes, do you know what your most recent hemoglobin A1C was? _____	If yes, what range do your sugars typically fall in? _____

CANCER SCREEN

Have you ever had cancer? ( ) yes ( ) no If so, what type(s) of cancer and when? If so, how was it treated? ( ) chemotherapy [dates: _____] ( ) radiation ( ) surgery

Do you have any history of the following (please check those that apply)? ( ) thyroid disease ( ) autoimmune disease ( ) Vitamin B12 deficiency ( ) excessive alcohol use ( ) infertility ( ) miscarriages ( ) cataracts ( ) a heart condition ( ) difficulty tolerating anesthesia ( ) HIV ( ) Hepatitis

Women's health issues: Are you currently pregnant? ( ) yes ( ) no ( ) unsure Do you plan to become pregnant within the next year? ( ) yes ( ) no ( ) unsure Are you currently breast-feeding? ( ) yes ( ) no	**Medication Allergies** (if you have an allergy to a particular medication, please list this medication and the reaction/symptoms it caused):

Did your current symptoms start around the time you started a new medication, herb, or supplement? ( ) yes ( ) no	If so, which one?
Have you ever taken a cholesterol-lowering medication? ( ) yes ( ) no	If so, which one?
Did your symptoms start following a trip to another country or another part of the US? ( ) yes ( ) no	If so, where?
Have you ever been exposed to any toxins or heavy metals that you are aware of? ( ) yes ( ) no	Which ones?

What testing have you had done for this issue thus far? ( ) none ( ) MRI brain ( ) CT scan brain ( ) MRI cervical spine/neck ( ) MRI thoracic spine/mid-back ( ) MRI lumbar spine/low back ( ) EMG/nerve conduction studies ( ) muscle biopsy ( ) nerve biopsy ( ) skin biopsy ( ) spinal tap ( ) blood work

Have you undergone any treatments or taken medications for this issue thus far? ( ) yes ( ) no If so, which ones?

SOCIAL HISTORY

Cigarettes/tobacco:	**Alcohol use:**
Do you currently smoke cigarettes/cigars or use other forms of tobacco? ( ) yes ( ) no	Do you drink alcohol? ( ) yes ( ) no
If not, but you once did, when did you quit? _____	About how many alcoholic beverages do you consume each month? _____
If you currently smoke cigarettes or did so in the past, approximately how many years have you/did you smoke(d) for? _____	What type of alcoholic beverage do you typically consume (i.e. beer, wine, hard alcohol, etc.)? _____
While smoking, approximately how many packs of cigarettes do you/did you smoke per day? _____packs or _____cigarettes per day	Do you have any history of significant alcohol use in the past? ( ) yes ( ) no
Recreational drugs: Do you use recreational drugs? ( ) yes ( )no Any significant drug use in the past? ( ) yes ( )no	**Diet:** Are you on any special type of diet (e.g. vegetarian)? ( ) yes ( ) no If yes, please specify type of diet:_____
Driving: Do you drive? ( ) yes ( ) no Do your symptoms impact your driving? ( ) yes ( ) no	**Home life:** Who do you live with? ( ) alone ( ) spouse ( ) children ( ) partner **( )** other
Activities of daily living: Are you UNABLE to perform any of the following tasks on your own? ( ) bathing ( ) grooming ( ) brushing your teeth ( ) selecting proper clothing ( ) putting on clothes ( ) eating ( ) controlling urine/bowel movements ( ) transferring, such as moving from bed to chair or to standing	
Marital status: ( ) single ( ) married ( ) divorced	

FAMILY MEDICAL HISTORY:

Family Member	Alive or deceased?	If alive, current age	If deceased, lived to age:	Medical conditions
Mother				
Father				
( ) Brother/ ( ) Sister				
( ) Brother/ ( ) Sister				
( ) Brother/ ( ) Sister				
( ) Brother/ ( ) Sister				
( ) Son/( ) Daughter Name:				
( ) Son/( ) Daughter Name:				
( ) Son/( ) Daughter Name:				
( ) Son/( ) Daughter Name:				
Maternal grandmother				
Maternal grandfather				
Paternal grandmother				
Paternal grandfather				
Other Family Members:				

Do you have any family history of nerve or muscle disease, or any family members who experience the same symptoms as you? ( ) yes ( ) no If so, explain:
Does anyone in your family have high foot arches? ( ) yes ( ) no
Does anyone in your family have cataracts? ( ) yes ( ) no
Does anyone in your family have heart disease? ( ) yes ( ) no

PLEASE PUT A CHECK TO THE LEFT OF ANY OF THE FOLLOWING SYMPTOMS YOU HAVE CURRENTLY OR HAD IN THE PAST:

CONSTITUTIONAL	**NEUROLOGIC**
unexplained fevers	muscle twitching or any other unusual movements of the muscles
unexplained chills	balance problems
nightsweats	coordination difficulties
unintentional weight loss	problems with dexterity or fine motor movements
reduced appetite	numbness, tingling, burning, or any other unusual sensation
	muscle stiffness
	difficulty releasing your hand grip
INTEGUMENTARY	muscle aches
rashes or other skin symptoms	cramps
unusual changes in skin color or temperature	falls
	history of seizures
EYES	frequent morning headaches
vision loss	unexplained awakening or gasping during sleep
double vision	
drooping of the eyelids	**PSYCHIATRY**
difficulty moving your eyes	feelings of depression/history of depression
personal or family history of cataracts	thoughts of killing/harming yourself or others
EAR, NOSE, THROAT	**MUSCULOSKELETAL**
difficulty chewing	foot deformities (high foot arches, hammertoes, etc.)
difficulty swallowing, choking, or drooling	neck pain
mouth or genital ulcers	back pain
slurred speech	history of scoliosis
change in voice	joint pain/warmth/stiffness
hearing loss	history of ankle sprains/fractures/injuries
RESPIRATORY	**CARDIOVASCULAR**
breathing difficulties/shortness of breath	chest pain
cough	rapid/pounding/abnormal heartbeats (palpitations)
GENITOURINARY	
tea or coca-cola colored urine	
frequent urination	**AUTONOMIC**
difficulty starting urination	dry eyes
inability to empty bladder completely	dry mouth
	lightheadedness or fainting
GASTROINTESTINAL	urinary incontinence/lack of urine control
a feeling of fullness after eating small amounts of food	bowel incontinence/lack of bowel control
abdominal bloating	erectile dysfunction
diarrhea	excessive sweating
constipation	decreased sweating
nausea or vomiting	
Check here if you have none of the symptoms in either column above	

Do you have any other symptoms that you think are relevant to your visit today? If so, please explain: