College of Medicine
Department of Neurology
Behavioral Neurology Division

Welcome to the University of Florida Memory and Cognitive Disorders Clinic & Memory Disorder Clinics.

Before You Come to Our Clinic

Enclosed are two packets. The larger packet asks for information about the person who has the doctor's appointment with us ('the patient'), and should be filled out by whoever best knows the problems and history of the patient. . The smaller packet must be filled out by someone **OTHER than the patient** who best knows the patient on a day to day basis (usually a close family member or friend). **Please complete these two packets before your appointment and bring them to the appointment for us to review.** We also highly recommend that you bring to clinic someone who knows the patient well, especially if they help with the patient's care at home.

Please also **BRING TO THE CLINIC** a list of all your medications and supplements (prescription and over the counter) as well as the actual medications in their original containers, copies of any medical notes you have about your problem, the results of any blood tests or other procedures for this problem, and any brain imaging (MRI, CT, PET, etc.) performed for this problem. **Any and all brain imaging done elsewhere than Shands Gainesville must be obtained by you on a disk with all the pictures on it from the imaging center at which the imaging was done!** Your doctor's office will not have or send these images on disk.

IMPORTANT – if you will need any translation or other special accommodations in order to answer questions and perform simple tasks for us during your visit, you must inform well prior to your appointment so arrangements can be made. Our tests usually require some degree of combined verbal and visual explanations and so a translator on the telephone is inadequate for this purpose.

A new evaluation in a Memory Disorders Clinic is not like a typical doctor's visit. Brain functions and diseases are complex and it takes several hours to fully examine a person. Your first visit with us you may **anticipate being here for 2 to 4 hours**; please make certain that you and those with you can stay for the entire half day. We pledge to reward your patience by being thorough!

When You Come to Our Clinic

It is important to check in at or before the time of your appointment. **If you are running later than 15 minutes, please call our office to inform us**. Arriving early may get you seen earlier, but we cannot guarantee it. **Arriving late may result in having to wait several minutes to hours to be seen or having to be rescheduled**, though we will do our best to try to see you in a timely fashion.

On arrival at the clinic please check in at the front desk and as soon as our nursing staff and room availability allows, you will be brought into the clinical area to have your vital signs taken and your forms reviewed by our nursing staff, and then wait in either the exam room or waiting room until one of our medical team is ready to begin your evaluation. **Our clinics are an academic practice in a teaching institution, so you will often begin your evaluation with a medical student, resident, fellow, or other health provider.** We have structured our clinics such that they are integral to our practice and their involvement in your care actually enhances our thoroughness and efficiency.

Often we are able to start your evaluation immediately, but sometimes there may be a delay, and there may also be points during your evaluation where we will need you to wait before the next step in evaluation. We want you comfortable during your visit with us, and **encourage you to bring reading material, electronic devices, game books or other entertainments as well as drinks and snacks that you may have while in our exam rooms.**

Return visits are typically much shorter with less breaks or delays, but they still may occur so the above advice is still valid for those visits.

For more information call 352-265-8408 or 352-294-5000.

Thank you for choosing the University of Florida Memory and Cognitive Disorders Clinic and we look forward to seeing you!

Patient's Name:_____ UF Health Medical Record Number:_____

Patient's Date of Birth:_____ Date of Office Visit:_____

MEMORY AND COGNITIVE DISORDERS CLINIC - BEHAVIORAL NEUROLOGY DIVISION
UNIVERSITY OF FLORIDA DEPARTMENT OF NEUROLOGY
INITIAL VISIT PACKET (To be answered by those who best know the patient's problem)

Chief Complaint (Reason for Today's Visit):_____

Hand with which patient writes (choose one):
Right Left Ambidextrous Born Right, now Left Born Left, now Right

Years of Education _____

Highest Degree (High School Graduate, Associate's Degree, Bachelor's Degree, Master's Degree, Ph.D., etc)
_____

Looking back now, how long ago did the very first change in memory or thinking start? _____

This problem started (choose one):
Abruptly (seconds to minutes)
Acutely (hours to days)
Subacutely (weeks to less than 6 months)
Gradually (over 6 months to years)

Looking back now, the very first change to the patient was in the area of (choose one):
Memory
Judgment & Problem Solving
Language
Getting Lost
Attention & Concentration

Over time this problem has been (choose all that apply):
Getting Worse
Staying the Same
Fluctuating
Transient
Getting Better

Is there anything that you associate with the start of this problem (such as a change in medications, illness, new stress, etc.)? If so, please explain on the line below?

_____

When did this problem become concerning? _____

What has been the most concerning thing about this problem?

_____

Patient's Name:_____ UF Health Medical Record Number:_____

Patient's Date of Birth:_____ Date of Office Visit:_____

Please circle all that the patient is having currently:

COGNITIVE PROBLEMS

MEMORY PROBLEMS
Forgetting dates
What people tell patient
Repeating questions & statements
Misplacing items more than usual
Forgetting names of people patient knows well

JUDGMENT & PROBLEM-SOLVING PROBLEMS
Handling money
Paying bills
Shopping
Preparing meals
Handling appliances

LANGUAGE PROBLEMS
Word finding difficulty
Using the wrong word without realizing it
Understanding what others say
Reading
Writing

VISUOSPATIAL PROBLEMS
Getting confused about directions
Misinterpreting everyday objects as something else

ATTENTION & CONCENTRATION PROBLEMS
Paying attention
Staying focused

DRIVING PROBLEMS (in the last year)
Accidents
Scrapes
Near misses
Restricted their driving (e.g. not at night, highways)
Others uncomfortable with the patient's driving

BEHAVIOR PROBLEMS

APATHY PROBLEMS
Lost interest in activities & social interactions
Decreased initiation of usual activities

DEPRESSION PROBLEMS
Sad more than two weeks at a time
Losing pleasure in activities
Hopelessness

VEGETATIVE PROBLEMS
Loss of appetite
Fatigue

REALITY PROBLEMS
Seeing things not present
Hearing noises no one else hears
Wondering if missing items have been stolen
Believing patient's partner is cheating on patient
Talking about memories/events that didn't happen

SOCIAL CONDUCT PROBLEMS
Using rough language
Inappropriate speech
Inappropriate behavior
Talking too personally to strangers
Having disregard for personal hygiene

TEMPER PROBLEMS
Getting impatient
Getting angry

CONTROL PROBLEMS
Sitting still
Shouting
Hitting
Kicking

NEW FOOD CRAVINGS
Craving? _____

COMPULSIVE BEHAVIORS
Such as: _____

Patient's Name:_____ UF Health Medical Record Number:_____

Patient's Date of Birth:_____ Date of Office Visit:_____

MOVEMENT PROBLEMS

WALKING PROBLEMS
Unsteadiness
Dragging feet
Decreased armswing
FALLS

TREMOR
Hands
Arms
Legs
Head
Mouth
Tongue

SLOWING OF MOVEMENTS
Walking
Moving
Handwriting

FACIAL EXPRESSION
Less expression
Wooden expression

REVIEW OF SYSTEMS

NERVOUS SYSTEM
Headaches
Trouble walking
Weakness
Numbness
Shaking
Passing out
Staring spells
Lightheadedness
Feeling of movement when not moving
Falls without passing out

VISION HEALTH
Wear corrective lenses
Vision good
Cataracts
Cataract surgery

HEARING HEALTH
Wear hearing aides
Hearing good

GENERAL HEALTH
General health is good
Poor sleep
Daytime sleepiness
More than 10 pound weight change (gain or loss)

MENTAL HEALTH
Enjoying life and doing things
Sadness
Seeing people or things not present
Hearing people or things not present

URINARY HEALTH
Incontinence when coughing or sneezing
Incontinence loosing full control of the bladder
Burning with urination
Abnormal bleeding with urination

HEART HEALTH
Severe chest pains
Palpitations
Irregular heartbeats

LUNG HEALTH
Shortness of breath
Cough
Coughing blood

ENDOCRINE HEALTH
Often cold
Often warm

SKIN HEALTH
New rashes
New skin growths
Changes in moles

GASTROINTESTINAL HEALTH
Good appetite
Frequent heartburn
Diarrhea
Constipation
Pains in stomach
Blood in stool

MUSCULOSKELETAL HEALTH
Joint pain & stiffness
Muscle aches & pains

Patient's Name:_____ UF Health Medical Record Number:_____

Patient's Date of Birth:_____ Date of Office Visit:_____

PAST MEDICAL HISTORY (Please list all past and current medical problems, even those controlled by medications)

High blood pressure
High cholesterol
Heart Disease
Atrial Fibrillation
Diabetes
Head injuries (any with loss of consciousness, if so, how long? _____)
Seizures or Epilepsy
Strokes

Migraines
Obstructive Sleep Apnea (with CPAP?)
Hypothyroidism
B12 Deficiency

Other Vitamin Deficiencies:
_____
Multiple Sclerosis
Syphilis
HIV
Attention Deficit Disorder
Learning disabilities
Depression
Bipolar Disorder
Obsessive Compulsive Disorder
Anxiety
Post-Traumatic Stress Disorder
Schizophrenia
Cancers:
_____

OTHER PAST MEDICAL HISTORY NOT MENTIONED ABOVE

_____

_____

_____

_____

_____

SURGICAL HISTORY

_____

_____

_____

_____

_____

Patient's Name:_____ UF Health Medical Record Number:_____

Patient's Date of Birth:_____ Date of Office Visit:_____

FAMILY HISTORY

Please list all family medical problems, even those controlled by medications; indicate before each the family affected (Brother, Sister, Father, Mother, Paternal Aunt, Paternal Uncle, Maternal Aunt, Maternal Uncle, Paternal Grandfather, Paternal Grandmother, Maternal Grandfather, Maternal Grandmother, etc.)

Family with this: Disease:

_____Alzheimer's Disease

_____Vascular Dementia

_____Parkinson's Disease

_____Lewy Body Disease

_____Corticobasal Degeneration

_____Progressive Supranuclear Palsy

_____Huntington's Disease

_____Amyotrophic Lateral Sclerosis

_____Creutzfeld-Jakob Disease

_____High blood pressure

_____High cholesterol

_____Diabetes

_____Seizures or Epilepsy

_____Strokes

_____Migraines

_____Heart Disease

_____Multiple Sclerosis

_____Attention Deficit Disorder

_____Learning disabilities

_____Depression

Family with this: Disease:

_____Bipolar Disorder

_____Anxiety

_____Schizophrenia

_____Cancers (list types below):

_____

Other Family Medical Problems:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient's Name:_____ UF Health Medical Record Number:_____

Patient's Date of Birth:_____ Date of Office Visit:_____

STATUS (First Degree Relatives Ages and Deaths)

Please list siblings, whether they and parents are alive or dead, ages (or age at death), and if dead, the cause.

Relation	Alive or Dead?	Age (or Age at Death)	Cause of Death (if dead)
Mother			
Father			
Brother or Sister?	Alive or Dead?	Age (or Age at Death)	Cause of Death (if dead)

SOCIAL HISTORY

TOBACCO USE

Smoking Status? (choose one)
Current Smoker
Former Smoker Date Quit: _____
Never Smoker (skip to smokeless tobacco question)

Types Used? (choose all that apply)
Cigarettes Pipe Cigars

Packs per day? _____

Number of Years Smoked: _____

Smokeless Tobacco
Current User
Former User Date Quit: _____
Never Used (skip to alcohol question)

Types
Snuff Chew

Patient's Name:_____ UF Health Medical Record Number:_____

Patient's Date of Birth:_____ Date of Office Visit:_____

ALCOHOL USE (choose one)
No (skip to drug use question) Yes Former

Number of Drinks per week (0.5 oz alcohol = 1 drink):_____

DRUG USE (choose one)
No (skip to sexual activity question) Yes Former
Use per week: _____

Types (choose all that apply)
IV
Cocaine
Marijuana
Methamphetamines
Other:_____

SEXUAL ACTIVITY?
Not Currently Yes

Partners (choose all that apply)
Male Female

Birth Control/Protection?
No (skip to occupation question) Yes (list type)

_____

OCCUPATIONS Still doing this Job?

_____

_____

_____

ETHNICITY HISPANIC (choose one)?
Yes No

RACE (choose all that apply)
American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Pacific Islander
White
Other _____

LANGUAGE
Patient Speaks English as (choose one):
First Language Second Language No English

Other Languages Spoken:

_____

_____

YEARS OF EDUCATION (total):_____

Any Years Repeated? (list year(s) here)_____

ALLERGIES AND ADVERSE REACTIONS

Drug Name Allergy or Side Effect? Type of Reaction Severity (Low, Medium, or High)

_____

_____

_____

_____

_____

Patient's Name:_____ UF Health Medical Record Number:_____

Patient's Date of Birth:_____ Date of Office Visit:_____

CURRENT MEDICATIONS

Please include over the counter and herbal supplements

Drug Name	Dose	Route (by mouth, etc.)	Frequency	Taking?

PERMISSIONS: Who makes medical decisions for the patient normally?_____

Who would make medical decisions for the patient if the patient cannot? _____

Who (family members, other caregivers, etc.) may we speak to about the patient's medical care?

_____

Patient's Name:_____ UF Health Medical Record Number:_____

Patient's Date of Birth:_____ Date of Office Visit:_____

MEMORY AND COGNITIVE DISORDERS CLINIC - BEHAVIORAL NEUROLOGY DIVISION
UNIVERSITY OF FLORIDA DEPARTMENT OF NEUROLOGY

UF MCD – INFORMANT PACKET

(MUST BE ANSWERED BY SOMEONE OTHER THAN THE PATIENT)

Please circle the most appropriate response.

Person filling out form: Spouse Child Other_____

1. Agitation or Aggression (Is the patient stubborn and resistive to help from others?)

No (if no, skip to next number) Yes

Severity for patient (choose one)?

Mild Moderate Severe

Distress for you the caregiver (choose one)?

Not distressed
Minimal
Mild
Moderate
Severe
Extreme

2. Hallucinations (Does the patient act as if he or she hears voices? Does he or she talk to people who are not there?)

No (if no, skip to next number) Yes

Severity for patient (choose one)?

Mild Moderate Severe

Distress for you the caregiver (choose one)?

Not distressed
Minimal
Mild
Moderate
Severe
Extreme

3. Delusions (Does the patient believe that others are stealing from him or her, or planning to harm him or her in some way?)

No (if no, skip to next number) Yes

Severity for patient (choose one)?

Mild Moderate Severe

Distress for you the caregiver (choose one)?

Not distressed
Minimal
Mild
Moderate
Severe
Extreme

4. Depression or Dysphoria (Does the patient act as if he or she is sad or in low spirits? Does he or she cry?)

No (if no, skip to next number) Yes

Severity for patient (choose one)?

Mild Moderate Severe

Distress for you the caregiver (choose one)?

Not distressed
Minimal
Mild
Moderate
Severe
Extreme

5. Anxiety (Does the patient become upset when separated from you? Does he or she have any other signs of nervousness, such as shortness of breath, sighing, being unable to relax, or feeling excessively tense?)

No (if no, skip to next number) Yes

Severity for patient (choose one)?

Mild Moderate Severe

Distress for you the caregiver (choose one)?

Not distressed
Minimal
Mild
Moderate
Severe
Extreme

6. Elation or Euphoria (Does the patient appear to feel too good or act excessively happy?)

No (if no, skip to next number) Yes

Severity for patient (choose one)?

Mild Moderate Severe

Distress for you the caregiver (choose one)?

Not distressed
Minimal
Mild
Moderate
Severe

Patient's Name:_____ UF Health Medical Record Number:_____

Patient's Date of Birth:_____ Date of Office Visit:_____

Extreme

7. Apathy or Indifference (Does the patient seem less interested in his or her usual activities and in the activities and plans of others?)

No (if no, skip to next number) Yes

Severity for patient (choose one)?

Mild Moderate Severe

Distress for you the caregiver (choose one)?

Not distressed
Minimal
Mild
Moderate
Severe
Extreme

8. Disinhibition (Does the patient seem to act impulsively? For example, does the patient talk to strangers as if he or she knows them, or does the patient say things that may hurt people's feelings?)

No (if no, skip to next number) Yes

Severity for patient (choose one)?

Mild Moderate Severe

Distress for you the caregiver (choose one)?

Not distressed
Minimal
Mild
Moderate
Severe
Extreme

9. Irritability or Liability (Is the patient impatient or cranky? Does he or she have difficulty coping with delays or waiting for planned activities?)

No (if no, skip to next number) Yes

Severity for patient (choose one)?

Mild Moderate Severe

Distress for you the caregiver (choose one)?

Not distressed
Minimal
Mild
Moderate
Severe

Extreme

10. Motor Disturbance (Does the patient engage in repetitive activities, such as pacing around the house, handling buttons, wrapping string, or doing other things repeatedly?)

No (if no, skip to next number) Yes

Severity for patient (choose one)?

Mild Moderate Severe

Distress for you the caregiver (choose one)?

Not distressed
Minimal
Mild
Moderate
Severe
Extreme

11. Nighttime Behaviors (Does the patient awaken you during the night, rise too early in the morning, or take excessive naps during the day?)

No (if no, skip to next number) Yes

Severity for patient (choose one)?

Mild Moderate Severe

Distress for you the caregiver (choose one)?

Not distressed
Minimal
Mild
Moderate
Severe
Extreme

12. Appetite and Eating (Has the patient lost or gained weight, or had a change in the food he or she likes?)

No (if no, skip to next number) Yes

Severity for patient (choose one)?

Mild Moderate Severe

Distress for you the caregiver (choose one)?

Not distressed
Minimal
Mild
Moderate
Severe
Extreme

Patient's Name:_____ UF Health Medical Record Number:_____

Patient's Date of Birth:_____ Date of Office Visit:_____

FUNCTIONAL ASSESSMENT SCALE

In the past four weeks, did the patient have any difficulty or need help with the following?

Rate on a scale of 0 – 3 as shown below:

0 – Can do this without help
1 – Has some difficulty but can do without help
2 – Need help with
3 – Can't do this

_____ Writing checks, paying bills, or balancing a checkbook?

_____ Assembling tax records, business affairs, or other papers?

_____ Shopping alone for clothes, household necessities, or groceries?

_____ Playing a game of skill or working on a hobby?

_____ Heating water, making coffee, or turning off the stove?

_____ Preparing a full meal?

_____ Keeping track of current events?

_____ Following a TV show, book or magazine and being able to discuss with acquaintances?

_____ Remembering appointments or remembering to take medications?

_____ Keeping track of recent conversations, recent events, and the date?

_____ Driving, traveling out of the neighborhood, or arranging to take public transportation?

_____ Total Score

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

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Movement Disorders & Neurorestoration Program

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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? _____