UFHealth
NORMAN FIXEL INSTITUTE FOR NEUROLOGICAL DISEASES

Normal Fixel Institute for Neurologic Diseases
Tourette Syndrome & Tic Disorders Center of Excellence

You have been scheduled to be seen in our Tourette syndrome, tics, and related disorders specialty clinic.

We will assess any involuntary or repetitive movements or vocalization. In addition, we will discuss other symptoms that may accompany the movements/sounds in some individuals.

Management of Tic Disorders and Tourette syndrome often times request a team of professionals that address all of the components of a tic condition. At your scheduled visit to the Fixel Institute for Neurologic Diseases, you will meet with a fellowship-trained movement disorders neurologist, who is one of the providers in this team.

Once the comprehensive exam is complete with the Neurologist, recommendations and referrals for other providers or professionals will be made if indicated. *(Often times, referrals to other providers are not necessary and no referrals will be indicated.)*

Below is a brief explanation of what to expect at this visit:

All patients will undergo the following at their visit:

1) A Neurology consultation with one of our fellowship-trained movement disorders Neurologists specializing in Tourette syndrome, tics, and other related disorders.
2) A short intake procedure with consent forms, self-questionnaires, and possible video diagnostics.
3) Feedback from your specialist(s) to discuss plan of care (including referral to other providers if indicated), resources, research opportunities and follow-up.

For your initial visit, a typical Neurology exam time is about 1 hour long. However, please plan to spend extended time with us, up to 3 hours, to ensure a comprehensive profile is addressed.

If you are unable to stay, please call us at the number below to reschedule this visit for a day when you are able to stay for an extended duration.

In order to assist the physician and ensure that your visit runs as smoothly as possible, please take a moment to review the following instructions:

1) Please ensure you bring your completed patient questionnaire with you to your appointment. This will streamline your first visit and allow the physician more time to discuss your medical history and evaluate your condition. Of particular importance are current medications and prior medications taken related to this condition.
2) Feel free to bring copies of additional relevant materials:
    a. Medical records, neuropsychological studies, psychiatric evaluations, school evaluations.
    b. Original imaging and reports (CT scan, MRI, PET scan, etc.) would be appreciated if available.

Please note that this list is not exhaustive. Please bring anything you feel would assist the specialists with their evaluations.

Please contact our scheduling department at 352.294.5000 with any questions or concerns.

UFHealth
NORMAN FIXEL INSTITUTE FOR NEUROLOGICAL DISEASES

New Patient Information Form
Tic & Tourette Clinic

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

Patient's name: _____
Person completing form: ☐ Self ☐Parent ☐Spouse ☐Other _____
Medical Record #: _____ Date: _____
Age: _____
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: _____

☐ Other: _____

Please state the main reason for this visit. *Just state your main symptom(s) or concerns; for example, "headache" or "tics." 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	_____	☐ Cancer	_____	☐ Tic Disorder	_____	☐ Asperger's Dis.	_____
☐ High Blood Pressure	_____	Location	_____	☐ Tourette Syndrome	_____	☐ Autism Spectrum Dis.	_____
☐ High cholesterol	_____	Type	_____	☐ Depression	_____	☐ Trichotillomania	_____
☐ Blood clots	_____	☐ Genetic Disorder	_____	☐ Anxiety	_____	☐ Skin-Picking	_____
☐ Diabetes	_____	Type	_____	☐ Bipolar	_____	☐ Develop Delay	_____
On insulin?	_____	☐ Sleep Apnea	_____	☐ ADD/ADHD	_____	☐ Sensory (SPD)	_____
☐ Reflux (GERD)	_____	☐ Sleep Disorder	_____	☐ OCD/OCD	_____	☐ Stereotypies	_____
☐ Dental/Oral	_____	☐ Migraines	_____	☐ ODD	_____	☐ Down Syndrome	_____
☐ Asthma	_____	☐ Headaches	_____	☐ Trichotillomania	_____	☐ Stereotypies	_____
☐ Arthritis	_____	☐ Epilepsy	_____	☐ Trauma	_____	☐ Social Skills Dis.	_____
☐ Fibromyalgia	_____	☐ Restless Legs	_____	Physical	_____	☐ Dysgraphia	_____
☐ Thyroid Disease	_____	☐ Tremors	_____	Emotional	_____	☐ Learning Dis.	_____
☐ Liver disease	_____	☐ Dystonia	_____	Sexual	_____	☐ Dyslexia	_____
☐ TMJ	_____	☐ Substance Abuse	_____	Other	_____	☐ Bed Wetting	_____
		☐ Alcohol Abuse	_____				

Other Medical History: _____

_____

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

Surgery	Date	Surgery	Date	Surgery	Date	Surgery	Date
☐ Eye surgery	_____	☐ Skin Cancer	_____	☐ Vasectomy	_____	☐ Joint Replace.	_____
☐ Tonsils	_____	☐ Other Cancer	_____	☐ Appendix	_____	Location	_____
☐ Adenoids	_____	Location	_____	☐ Bladder	_____	☐ Orthopedic	_____
☐ Ear Tubes	_____	Type	_____	☐ GI/Bowel	_____	Location	_____
☐ Dental/Oral	_____	☐ C-section	_____	☐ Deep Brain Stim.	_____	Type	_____
☐ Heart	_____	☐ Tubal Ligation	_____	☐ Other _____			

Allergies: Please list any medications to which you are allergic, and state the nature of the reaction.

_____

_____

Please continue on reverse side

Birth History:

Type of Delivery:

- ☐ Vaginal
- ☐ C-Section
- ☐ Unknown
- ☐ Other _____

Birth Delivery Details:

- ☐ Typical/No complications
- ☐ Full-Term
- ☐ Pre-mature _____ wks
- ☐ Forceps/vacuum
- ☐ Induced delivery
- ☐ Maternal drug use during pregnancy
- ☐ Extended NICU stay
- ☐ Other _____

Developmental Milestones:

- ☐ No concerns/age appropriate
- ☐ History of delayed /impaired:
  - ☐ speech
  - ☐ motor skills
  - ☐ social skills
  - ☐ toilet training
  - ☐ self-care skills
  - ☐ sensory processing

Social History:

Who Lives in Household:

- ☐ Alone
- ☐ With one parent
- ☐ Parents-Together
- ☐ More than one household
- ☐ Grandparent
- ☐ Adopted parents
- ☐ Foster parents
- ☐ Other caregiver
- ☐ Children (Ages?) _____
- ☐ Spouse
- ☐ Partner
- ☐ Roommate(s)

Total members in the house: _____

Household Type:

- ☐ House
- ☐ Apartment
- ☐ Condo/Townhome
- ☐ Foster Home
- ☐ Homeless
- ☐ Other _____

Living Situation:

- ☐ Owned home
- ☐ Rented Place
- ☐ State Care/Foster Care
- ☐ Assisted Living Facility
- ☐ Other: _____

Sexual History:

Gender:

- ☐ Male
- ☐ Female
- ☐ Transgender M/F
- ☐ Transgender F/M
- ☐ I don't label myself
- ☐ Other

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Cohabitating
- ☐ Partnered
- ☐ Other

Sexual Orientation:

- ☐ Lesbian
- ☐ Straight
- ☐ Gay
- ☐ Bisexual
- ☐ Asexual
- ☐ Prefer not to answer

Drug Use:

Alcohol History:

- ☐ Never drinks
- ☐ Quit:
  When? _____
- ☐ Yes
  Drinks per week _____

Substance Use

- ☐ Never_____
- ☐ Marijuana/Cannabis/CBD Use
  Prescribed? _____
  Frequency _____
- ☐ Other Drugs: _____
  Frequency _____
- ☐ Quit: When? _____

Tobacco History:

- ☐ Never smoked
- ☐ Prior Smoker/Quit
  Quit smoking in _____
- ☐ Currently smoking
  Packs per/day _____
- ☐ Dipping or Vaping Use
  Amount per/day _____

Educational & Occupational History:

Occupational Status

- ☐ Student
- ☐ Working Part-Time
- ☐ Working Full-Time
- ☐ Retired
- ☐ Disabled
- ☐ Volunteering
- ☐ Unemployed

Education Completed

- ☐ Grade School
- ☐ High School/GED
- ☐ Some College
- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ PhD and above

Leisure Activities

- ☐ Never engage in leisure
- ☐ Limited leisure
- ☐ Most of the day is leisure
- ☐ Unsure of leisure resources

Prior Services:

Services Receiving	Past	Current	Comments
☐ Psychology/Mental Health Services	☐	☐	
☐ Behavioral Therapy	☐	☐	
☐ Psychiatry	☐	☐	
☐ Occupational Therapy	☐	☐	
☐ Speech Therapy	☐	☐	
☐ Physical Therapy	☐	☐	
☐ Comprehensive Behavioral Intervention for Tics (CBIT)	☐	☐	
☐ Tutoring	☐	☐	
☐ Vocational Rehabilitation	☐	☐	
☐ Other _____	☐	☐	

Medications: Please review carefully and complete the following medications chart to the best of your availability.

Medication	Ever Taken?	Start/Stop Date (if known)	Dosage	Side Effects	Benefit: W= Worse I= Improved N= No Change U= Unknown
Neuroleptics:					
Haloperidol (Haldol)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Fluphenazine (Prolixin)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Pimozide (Orap)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Atypical Neuroleptics:					
Olanzapine (Zyprexa)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Quetiapine (Seroquel)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Risperidone (Risperidal)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Ziprasidone (Geodon)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Aripiprazole (Abilify)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Dopamine Delpletors:					
Tetrabenazine (Xenaxine)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Valbenazine (Ingrezza)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Deutetrabenazine (Austedo)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Alpha Agonists:					
Clonidine (Catapres)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Guanfacine (Tenex)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
SSRIs:					
Citalopram (Celexa)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Clomipramine (Anafranil)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Fluoxetine (Prozac)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Fluvoxamine (Luvox)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Paroxetine (Paxil)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Sertraline (Zoloft)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Antidepressants:					
Bupropion (Wellbutrin)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Mirtazapine (Remeron)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Nefazadone (Serzone)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Nortiptyline (Pamelor)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Venlafaxine (Effexor)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Psychostimulants (ADHD):					
Amphetamine (Dexedrine, ADDerall)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Methylphenidate (Ritalin, Concerta…)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Deximethylphenidate (Focalin)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Atomoxetine (Strattera)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Mood Stabilizers and Anticonvulsants:					
Carbamazepine (Tegretol)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Gabapentin (Neurontin)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Lamotrigine (Lamictal)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Lithium carbonate	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Oxcarbazepine (Trileptal)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Tiagabine (Gabatril)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Topiramate (Topamax, Trokendi XR)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Valproic acid (Depakote, Depakene)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Benzodizepines:	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Clonzaepam (Klonopin)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Lorazepam (Ativan)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Diazepam (Valium)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Others/Injections:					
Botulinum toxin (Botox)	☐Yes ☐No				☐ W ☐ I ☐N ☐U
Marijuana	☐Yes ☐No				☐ W ☐ I ☐N ☐U
CBD	☐Yes ☐No				☐ W ☐ I ☐N ☐U

Please continue on reverse side

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
	Any neurologic disorder		High blood press.
	Parkinson's disease		Diabetes
	Neuropathy		Heart disease
	Dystonia		Cancer
	Muscle problem		Alzheimer's disease
	Stroke		Other dementia
	Tics/Tourette		Tremors
	ADHD		OCD
	Anxiety disorder		Depression
	Other_____		

Review of symptoms: Please check any symptoms that you have recently experienced or have concerns about:

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fatigue
- ☐ Profuse Sweating
- ☐ Weakness
- ☐ Sexual dysfunction
- ☐ Pelvic pain

Skin
- ☐ Rash
- ☐ Itching
- ☐ Skin picking
- ☐ Hair Pulling
- ☐ Skin hypersensitivity

Head/ENT
- ☐ Headaches
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Ear pain
- ☐ Ear Discharge
- ☐ Nose bleeds
- ☐ Loss of smell

- ☐ Congestion
- ☐ Wheezing
- ☐ Sore throat

Ophthalmologic
- ☐ Blurred vision
- ☐ Double vision
- ☐ Sensitivity to light
- ☐ Eye pain
- ☐ Eye Discharge
- ☐ Eye Redness
- ☐ Wears glasses
- ☐ Wears contacts

Cardiovascular
- ☐ Chest pain
- ☐ Pounding heart
- ☐ Shortness of breath
- ☐ Leg Swelling
- ☐ Lightheaded on standing
- ☐ Fainting

Respiratory
- ☐ Cough
- ☐ Coughing up blood
- ☐ Phlegm production
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Excessive thirst

Endocrine
- ☐ Breast changes
- ☐ Fatigue
- ☐ Hair Pulling
- ☐ Skin picking

Genitourinary
- ☐ Painful urination
- ☐ Urgency
- ☐ Urinating often
- ☐ Blood in urine
- ☐ Side pain
- ☐ Waking to urinate
- ☐ Bedwetting

Gastrointestinal
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Stomach pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Dark tarry-like stool
- ☐ Appetite Changes
- ☐ Picky eating

Allergy/Immunology
- ☐ Easy to bruise
- ☐ Seasonal Allergies
- ☐ Excessive thirst
- ☐ Frequent Strep throat

Neurological
- ☐ Dizziness
- ☐ Tingling
- ☐ Tremors
- ☐ Change in sensation
- ☐ Speech changes
- ☐ Weakness
- ☐ Seizures
- ☐ Loss of consciousness
- ☐ Abnormal Movements
- ☐ Poor concentration
- ☐ Restless legs
- ☐ Vocal Tics
- ☐ Motor Tics
- ☐ Stereotypies
- ☐ Tremors

School Functioning
- ☐ Difficulties at school
- ☐ Learning difficulties
- ☐ Handwriting difficulties
- ☐ Being bullied
- ☐ Poor grades

Occupational Functioning
- ☐ Difficulties at home
- ☐ Difficulties making friends
- ☐ Difficulties with others
- ☐ Difficulties at work
- ☐ Difficulties with travel

Musculoskeletal
- ☐ Muscle pain
- ☐ Muscle cramps
- ☐ Neck pain
- ☐ Back pain
- ☐ Joint pain
- ☐ Falls
- ☐ Muscle cramps
- ☐ Weakness

Psychological/Psychiatric
- ☐ Depression
- ☐ Suicidal thoughts
- ☐ Substance abuse
- ☐ Hallucinations
- ☐ Nervousness/Anxiety
- ☐ Sleep difficulties
- ☐ Memory loss
- ☐ Obsessive behavior
- ☐ Compulsive behavior
- ☐ Hoarding
- ☐ Irritability
- ☐ Rage
- ☐ Impulsive Behaviors
- ☐ Attention Difficulties
- ☐ Hyperactivity
- ☐ Mood Difficulties
- ☐ Self-Harming

Other
- ☐ _____
- ☐ _____

Thank you for your assistance.

Patient/Caregiver signature: _____ Date: _____

I have reviewed this history with the patient.

Physician's signature: _____ Date: _____

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
Department of Neurology

3009 SW Williston Rd
Gainesville, FL 32608
Tel: 352-294-5400
Fax: 352-627-4867

New Patient Appointment Information

We would like to welcome you to the Fixel Center for Neurological Diseases at UF Health's Movement Disorders & Neurorestoration Program. To help you prepare for your first visit with our clinic, please take a few moments to carefully review this information so that you will be better informed about what to expect at your new patient evaluation.

1) Please review the medication list at the bottom of this page. If you are taking any of these medications, please **STOP** these medications **at least 12 hours prior** to your first appointment and do not restart them until have been instructed to do so by our clinic.
    a. **If you are not taking any of the medications listed below, please continue to take your medications as directed by your local physician.**
2) Please ensure you bring your completed New Patient Information Form and Medication Questionnaire with you to your appointment. This will streamline your first visit and allow the physician more time to focus on the specific medical issue which has brought you to our Center.
3) Please bring **ALL** of your current medications with you to your visit.
4) Please come prepared to discuss the following:
    a. Past medications you have taken and why you stopped them.
    b. Past surgical procedures relevant to your movement disorder.
    c. Any family medical history that may be relevant to your movement disorder.
5) Please bring any additional relevant medical records or other examinations that your referring physician's office may not have sent us. Also, please make sure to bring the films and/or CDs from any relevant radiological studies (CT, MRI, X-ray, PET scan, etc.) that you have had done within the last **2 years**.

*Our staff is available to answer any questions you may have concerning your new patient evaluation. Also, we are happy to try and assist with some special arrangements if you will be in need of assistance during your visit. Please call **(352) 294-5400** to reach a member of our scheduling team.*

Due to the special nature of this evaluation, it is necessary for you to **STOP** any of the following medications for at least **12 hours prior** to your scheduled appointment time:

Carbidopa/Levadopa, Sinemet, Rytary, Neupro, Azilect, Adamet, Mirapex, Amantadine, Requip, Parlodel, Comtan, Stalevo, Parcopa, Apokyn, Zelapar, Tasmar. **If your medication is NOT listed, we cannot advise you to stop that medication prior to your visit. Please consult with your local physician.**

--SINEMET CR , SINEMET ER, MIRAPEX ER, and REQUIP XL--
These medications should be stopped **24-hours prior to your visit!!**
*****If you are coming for a two day evaluation and currently have a deep brain stimulator in place, please make sure you DO NOT restart any of the medications listed above until you have been instructed to do so by our clinic .*****
******You should take all other medications and eat a normal breakfast or lunch.******