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
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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.******

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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)

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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? _____