

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/Levodopa, 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.****



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:

Table with 8 columns: Disorder, Onset, Disorder, Onset, Disorder, Onset, Disorder, Onset. Rows include Heart Disease, Atrial Fibrillation, Blood clots, Stroke, Epilepsy, Liver disease, Depression, High Blood pres., High cholesterol, Diabetes, Cancer, Anxiety, Lung disease, Asthma, Kidney failure, Trauma, Head, Neck, Other, OCD, Thyroid disease, Migraine, Sleep disorder, Miscarriages, Reflux (GERD), Fibromyalgia, ADD/ADHD.

Other Medical History:

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

Table with 8 columns: Surgery, Date, Surgery, Date, Surgery, Date, Surgery, Date. Rows include Heart, Bypass graft, Stent, Cancer, Colon polyp, C-section, Gall bladder, Breast lump, Appendix, Tonsils, Hysterectomy, GI bypass/stapling, Hernia, Vasectomy, Bladder, Brain, Neck, Hip replacement, Knee replacement, Cataract, Other surgeries.

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:

Table with 2 columns: Abbreviation, Relationship. Rows: M Mother, F Father, B Brother, S Sister, C Child, GP Grandparent, O Other.

Table with 6 columns: Rel., Disease, Rel., Disease, Rel., Disease. Rows: 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.

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

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: _____

Which pronouns you prefer to be used when addressing you?

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

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

- Yes
- No
- Prefer not to disclose

Do you think of yourself as?

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

(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)

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

<u>Sinemet (Carbidopa/Levodopa)</u>	Strength (mg):	<input type="checkbox"/> 10/100	<input type="checkbox"/> 25/100	<input type="checkbox"/> 25/250	
<input type="checkbox"/> Still Taking	<input type="checkbox"/> Stopped	# of doses per day: _____	# of tablets per dose: _____		
If stopped, why? _____					
<u>Sinemet CR (Carbidopa/Levodopa Controlled Release)</u>	Strength (mg):	<input type="checkbox"/> 25/100	<input type="checkbox"/> 50/200		
<input type="checkbox"/> Still Taking	<input type="checkbox"/> Stopped	# of doses per day: _____	# of tablets per dose: _____		
If stopped, why? _____					
<u>Rytary (Carbidopa/Levodopa Extended Release)</u>	Strength (mg):	<input type="checkbox"/> 23.75/95	<input type="checkbox"/> 36.25/145	<input type="checkbox"/> 48.75/195	<input type="checkbox"/> 61.25/245
IPX066	<input type="checkbox"/> Still Taking	<input type="checkbox"/> Stopped	# of doses per day: _____	# of tablets per dose: _____	
If stopped, why? _____					
<u>Stalevo</u>	Strength (mg):	<input type="checkbox"/> 50mg	<input type="checkbox"/> 100mg	<input type="checkbox"/> 150mg	<input type="checkbox"/> 200mg
<input type="checkbox"/> Still Taking	<input type="checkbox"/> Stopped	# of doses per day: _____	# of tablets per dose: _____		
If stopped, why? _____					
<u>Eldepryl (selegiline)</u>	Strength (mg):	5mg			
<input type="checkbox"/> Still Taking	<input type="checkbox"/> Stopped	# of doses per day: _____	# of tablets per dose: _____		
If stopped, why? _____					
<u>Azilect (rasagiline)</u>	Strength (mg):	<input type="checkbox"/> 0.5mg	<input type="checkbox"/> 1.0mg		
<input type="checkbox"/> Still Taking	<input type="checkbox"/> Stopped	# of doses per day: _____	# of tablets per dose: _____		
If stopped, why? _____					
<u>Parcopa</u>	Strength (mg):	<input type="checkbox"/> 25/100	<input type="checkbox"/> 25/250		
<input type="checkbox"/> Still Taking	<input type="checkbox"/> Stopped	# of doses per day: _____	# of tablets per dose: _____		
If stopped, why? _____					
Form Continues on Back					

<p><u>Mirapex (pramipexole)</u> Strength (mg): ___ 0.125mg ___ 0.25mg ___ 0.5mg ___ 1.0mg ___ 1.5mg</p> <p>___ Still Taking ___ Stopped # of doses per day: ___ # of tablets per dose: ___</p> <p>If stopped, why? _____</p>
<p><u>Neupro (rotigotine)</u> Strength (mg): ___ 2mg ___ 4mg ___ 6mg ___ 8mg</p> <p>___ Still Taking ___ Stopped # of doses per day: ___ # of tablets per dose: ___</p> <p>If stopped, why? _____</p>
<p><u>Apokyn (apomorphine)</u> Strength (mg): ___ 10mg/ml</p> <p>___ Still Taking ___ Stopped # of doses per day: ___ # of tablets per dose: ___</p> <p>If stopped, why? _____</p>
<p><u>Requip (ropinirole)</u> Strength (mg): ___ 0.25mg ___ 0.5mg ___ 1mg ___ 2mg ___ 3mg ___ 4mg ___ 5mg</p> <p>___ Still Taking ___ Stopped # of doses per day: ___ # of tablets per dose: ___</p> <p>If stopped, why? _____</p>
<p><u>Artane (trihexyphenidyl)</u> Strength (mg): ___ 2.0mg ___ 5.0mg</p> <p>___ Still Taking ___ Stopped # of doses per day: ___ # of tablets per dose: ___</p> <p>If stopped, why? _____</p>
<p><u>Comtan (entacapone)</u> Strength (mg): ___ 200mg</p> <p>___ Still Taking ___ Stopped # of doses per day: ___ # of tablets per dose: ___</p> <p>If stopped, why? _____</p>
<p><u>Congentin (benztropine)</u> Strength (mg): _____</p> <p>___ Still Taking ___ Stopped # of doses per day: ___ # of tablets per dose: ___</p> <p>If stopped, why? _____</p>
<p><u>Tasmar (tolcapone)</u> Strength (mg): ___ 100mg ___ 200mg</p> <p>___ Still Taking ___ Stopped # of doses per day: ___ # of tablets per dose: ___</p> <p>If stopped, why? _____</p>
<p><u>Symmetrel (amantadine)</u> Strength (mg): ___ 100mg</p> <p>___ Still Taking ___ Stopped # of doses per day: ___ # of tablets per dose: ___</p> <p>If stopped, why? _____</p>