UF | Center for Movement Disorders and Neurorestoration
UNIVERSITY of FLORIDA

New Patient Information Form

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

Patient's name: _____
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: _____
☐ Yourself
☐ Other: _____

Please state the main reason for this visit. *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	_____			☐ _____	_____

Social History:

Marital Status:
☐ Single
☐ Married
☐ Divorced

You live with:
☐ Alone
☐ Spouse
☐ Children
☐ Partner
☐ Other: _____

You live at:
☐ Your home
☐ Relative's home
☐ Assisted Living Facility
☐ Nursing home
☐ Other: _____

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

Current or most recent occupation:
_____
☐ Retired – year: _____
☐ Disabled – year: _____

Do you use alcohol?
☐ Never
☐ Quit: When? _____
☐ Yes: Drinks per week _____

Smoking history:
☐ Never smoked
☐ Currently smoke _____ packs/day
☐ Quit smoking in _____
Lifetime cigarette use:
____ packs/day for ____ years

Please continue on reverse side

Have you ever had: ☐ Blood Transfusion; ☐ Hepatitis: type ☐ A; ☐ B; ☐ C; ☐ HIV (AIDS); ☐ Substance abuse

Family History

	Alive (give age)	Died (at age)	Of (cause of death)
Mother			
Father			

Siblings (give numbers):

Sisters: _____ Brothers: _____

Children (give numbers):

Girls: _____ Boys: _____

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 dis.		High blood press.
	Dementia		Diabetes
	Neuropathy		Heart disease
	Dystonia		Cancer
	Muscle problem		Parkinson's
	Stroke		Alzheimer's
	Tics/Tourette		Tremors

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

Medication	*Reaction*

Medications: List below, or provide the doctor or nurse with a list.

Medication	*Dose*	*Frequency*	*Medication*	*Dose*	*Frequency*

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

☐ Headache	☐ Trouble sleeping	☐ Poor appetite	☐ Over 10 lbs weight loss	☐ Irregular periods
☐ Neck pain	☐ Daytime drowsiness	☐ Nausea	☐ Over 10 lbs weight gain	☐ Heavy periods
☐ Back pain	☐ Fainting/Blackouts	☐ Vomiting	☐ Pain on urination	☐ Lumps in breast
☐ Pain in limbs	☐ Seizures/epilepsy	☐ Diarrhea	☐ Trouble starting urine	☐ Breast discharge
☐ Joint pain	☐ Memory Loss	☐ Constipation	☐ Trouble holding urine	☐ Rash
☐ Stomach pain	☐ Hallucinations	☐ Bloody/tarry stool	☐ Blood in urine	☐ Easy bruising
☐ Other pain	☐ Confusion	☐ Chest pain	☐ Urinating often	☐ Growing moles
☐ Weakness	☐ Nervousness	☐ Shortness of breath	☐ Waking to urinate	☐ Arthritis
☐ Muscle cramps	☐ Irritability	☐ Persistent cough	____ times per night	List other symptoms:
☐ Numbness/tingling	☐ Anxiety	☐ Coughing up blood	☐ Sexual dysfunction	☐ _____
☐ Trouble seeing	☐ Depression/sadness	☐ Ankle swelling	☐ Fever/chills	☐ _____
☐ Trouble hearing	☐ Fatigue	☐ Trouble sleeping flat	☐ Unusual thirst	☐ _____
☐ Trouble swallowing	☐ Runny nose	☐ Swollen lymph nodes	☐ Lightheaded on standing	☐ _____
☐ Trouble with speech	☐ Excessive sneezing	☐ Dizziness	☐ Vertigo (spinning)	☐ _____

Thank you for your assistance.

Patient's signature: _____ Date: _____

I have reviewed this history with the patient.

Physician's signature: _____ Date: _____