TAMPA NEUROLOGY ASSOCIATES

Please be as complete as possible

PATIENT QUESTIONNAIRE

Name: **Age:** **Date of visit:**

DOB: **Height:** **Weight:**

REFERRING PHYSICIAN: **Primary Doctor:**

MAIN REASON FOR VISIT TODAY:

Email address: **BEST CONTACT Phone#:**

HAVE YOU BEEN ADMITTED/HOSPITALIZED AT TAMPA GENERAL HOSPITAL, MEMORIAL HOSPITAL, or ST. JOSEPH'S HOSPITAL IN THE LAST 3 YEARS? Yes____ NO_____, (circle hospital) Did you bring your records? Y /N

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	NO	Date
Arthritis			
Cancer			
Cholesterol problems			
Depression			
Diabetes			
Heart Rhyhm problem			
Heart Attack			
High Blood Pressure			
HIV/AIDS			
Falls			
Multiple Sclerosis			
Memory Loss			
Meningitis			
Migraine Headaches			
Neuropathy			
Seizure			
Stroke			
Syncope			

CURRENT MEDICATIONS

Name	Dose	Frequency

ALLERGIES

SOCIAL HISTORY

Marital status: S /M /D /W

Occupation:

Children: Y/N Ages:

Tobacco: Y/N Quit? Y/N When?

Alcohol: Y/N How often?

Drug use: Y/N

PAST SURGERIES AND DATES	

Do you have a living will? Y / N

Do you have advanced care plan? Y / N

Do you have power of attorney? Y/ N

Name of Surrogate Decision Maker :

FAMILY MEDICAL HISTORY

	Alive/Dead	Cause of death/ List all Illness (es)	
mother			
father			
sister(s)			
brother(s)			
MGM			
MGF			
PGM			
PGF			
Other			

PHARMACY USED:

Address:

LAB FREQUENTLY USED: LABC / QUEST/ OTHER

TAMPA NEUROLOGY ASSOCIATES

Date	

DO YOU CURRENTLY HAVE? **(Please √ if you have any of the following, use ? If unsure.)**

General	Fatigue		Fever		
	Weight Loss		Weight gain		
	Memory loss		**Gastrointestinal**		
Skin	Rash		Loss of appetite		
	Skin cancer		Nausea		
Head/Neck	Headaches		Vomiting		
	Head injury		Blood in Stool		
	Neck pain		Changes in Bowel habits		
	Blurred Vision		Ulcers		
	Double Vision		**Gynecological**		
	Hearing Loss		Irregular Menses		
	Ears Ringing		Abnormal Vaginal bleeding		
	Vertigo or Dizziness		Pregnancy		
	Hoarseness		Contraceptive use		
	Difficulty Swallowing		Post Menopausal		
Respiratory	Cough		**Behavioral**		
	Asthma		Drug abuse		
	Shortness of Breath		STD		
	Pneumonia		Unsafe sexual practices/HIV		
	TB		Insomnia		
Cardiac	Angina/Chest Pain		**Hematological**		
	Irregular heart beat		Transfusions		
	Heart failure		Anemia		
	Rheumatic fever		Cancer or Malignancy		
Renal/Urinary	Kidney devices		Clotting disorder		
	Change in bladder habits		**Endocrine/Metabolic**		
	Blood in urine		Diabetes		
	Kidney Stones		Thyroid problems		
Emotional/Psychiatric	Depression		**Bone/Joints**		
	Anxiety		Pain		
	Suicidal thoughts		Swelling		
Previous Psychological Counseling			Injury		

What is your main concern to discuss with your neurologist?

	YES	**NO**
Have you fallen in past year?		
Do you have a plan of care?		
Do you have a living will?		
Do you have an advanced care plan?		
Do you have a health care surrogate?		
Do you smoke?		
Do you drink?		
Did you get the Flu Shot 2015-2016?		

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TAMPA NEUROLOGY ASSOCIATES

RETURN VISIT QUESTIONNAIRE NAME Date

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					YES	**NO**
CHANGES TO MEDICATIONS (if any)				Have you fallen in past year?		
Medication	Dose	Frequency		Do you have a living will?		
				Do you have a power of attorney?		
				Do you have a health care surrogate?		
				Do you have an advanced care plan?		
				Do you smoke?		
				Do you drink?		
TESTS SINCE THE LAST VISIT				Did you get the Flu Shot 2015-16?		
Name of test	Date	Location				
				WHO IS YOUR PCP/REF MD?		
				Fax # for PCP/Ref MD		

SIGNATURE