TMH PHYSICIAN PARTNERS - NEUROLOGY SPECIALISTS

Core Patient Packet

1401 Centerville Road Suite 504, Tallahassee, Florida 32308

For questions, please call 850-431-5001

1. Please describe the reason for you visit: _____

_____

_____

2. How did you hear about us:_____
3. Do you have an Advanced Directive/Living Will: ❑ Yes ❑ No
4. Have you fallen in the last year? ❑ Yes ❑ No
5. Do you feel unsteady when you are standing or walking: ❑ Yes ❑ No
6. Have you had any unexplained weight change in the last 3 months?
   ❑ Loss ❑ Gain ❑ No change
7. Do you use any of the following:
   ❑ Glasses ❑ Hearing Aids ❑ Dentures ❑ Cane ❑ Walker ❑ Wheelchair
8. What is the highest grade/level of education you finished?
   ❑ Middle School ❑ High School ❑ Associate's Degree
   ❑ Bachelor's Degree ❑ Graduate Degree ❑ Post Graduate
   ❑ Other:_____
9. Do you drink alcohol? ❑ Yes ❑ No.
   If yes, how much and how often?_____
   If you drank alcohol previously, when did you stop? _____
10. Do you now/have you ever used any illegal drugs? ❑ Yes ❑ No
    If you quit using drugs, when did you stop?:_____
11. Do you smoke? ❑ Yes ❑ No
    If yes, how long have you smoked/how many packs a day?_____
    If you quit smoking, when did you stop: _____
    How many years did you smoke?_____
    How many packs per day ?_____
13. Have you had any recent bowel/bladder problems: ❑ Yes ❑ No
14. Are you in a relationship where you feel threatened or hurt: ❑ Yes ❑ No

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15. Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not At All	Several Days	More than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				

16. Have you ever had an injury to your back or neck? If so, please describe.

_____

17. Are you right or left handed? ❑ Right ❑ Left

18. Occupation: _____

19. Who do you live with : ❑ Alone ❑ Spouse/Partner ❑ Children ❑ Siblings ❑ Friends

19. How many children do you have?_____ Are they healthy?_____

_____

If not, what diseases do they suffer from?_____

21. Is your mother living? ❑ Yes ❑ No. If no, when and how did she die:_____
Mother's illnesses or conditions:_____
Age at death:_____ ❑ Unknown

22. Is your father living? ❑ Yes ❑ No. If no, when and how did he die:_____
Father's illnesses or conditions:_____
Age at death:_____ ❑ Unknown

23. How many brothers _____and sisters_____ do you have ? ❑ Unknown
Please list their medical problems:_____

_____

25. Has anyone in your family had cancer or a neurological disease? Please list: _____

_____

Please list all of the medicines you are taking (include over the counter medicines like aspirin and vitamins), the reason for taking them, the dose and the frequency. ***Bring ALL medicines to your appointment.***

Which pharmacy do you use? _____ Phone number:_____

Medicine	Dose	Frequency	Reason

Please list **ALL** your allergies to medications and the reaction that you have:

1. _____

2. _____

3. _____

4. _____

5. _____

Please list all doctors, therapists and/or providers currently treating you:

Name	Specialty

Please list all hospitalizations and surgeries:

Reason	Year	Anesthesia?
		❑ Y ❑ N
		❑ Y ❑ N
		❑ Y ❑ N
		❑ Y ❑ N
		❑ Y ❑ N
		❑ Y ❑ N

Do you have, or have you had, any of the following:

- ❑ ADD/ADHD/Learning Disability
- ❑ Angina
- ❑ AIDS/HIV Positive
- ❑ Anxiety
- ❑ Atrial Fibrillation
- ❑ Arthritis
- ❑ Asthma
- ❑ Bronchitis
- ❑ Bipolar Disorder
- ❑ Blood Disorder
- ❑ Cancer _____
- ❑ Celiac Disease
- ❑ Chronic Pain/Fibromalgia
- ❑ Concussion/Head Injury
- ❑ Dementia
- ❑ Depression
- ❑ Diabetes
- ❑ Fractures
- ❑ GERD
- ❑ Glaucoma
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Hypoglycemia
- ❑ Insomnia
- ❑ Irritable Bowel Syndrome
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Lung Disease
- ❑ Lupus
- ❑ Macular Degeneration
- ❑ Migraines/Headaches
- ❑ Multiple Sclerosis
- ❑ Parkinson's Disease
- ❑ Peripheral Neuropathy
- ❑ Polio
- ❑ Seizures/Epilepsy
- ❑ Sleep Apnea
- ❑ Stroke/TIA
- ❑ Thyroid Disease

Please list other medical conditions/chronic illnesses not listed above:

_____

_____

_____

Review of Systems

Please check all that apply to you:

Constitutional	❑ Fever	❑ Malaise
	❑ Chills	❑ Fatigue
Head and Face	❑ Facial pain	
	❑ Facial pressure	
Eyes	❑ Eye pain	❑ Puss/discharge
	❑ Red eyes	❑ Itchy eyes
	❑ Watery discharge	❑ Blurred vision
Ear, Nose and Throat	❑ Earache	❑ Sore throat
	❑ Hearing loss	❑ Scratchy throat
	❑ Nasal congestion	❑ Hoarseness
	❑ Drainage from nose	❑ White patches in mouth
	❑ Sneezing	
Cardiovascular	❑ Chest pain	❑ Lightheadedness
	❑ Palpitations	❑ Swelling in legs
	❑ Racing heart	
Respiratory	❑ Shortness of breath	❑ Cough
	❑ Wheezing	❑ Dry cough
	❑ Coughing up blood	❑ Productive cough
	❑ Clear sputum	❑ Colored sputum
	❑ Sleep upright/extra pillows	
Gastrointestinal	❑ Abdominal pain	❑ Nausea
	❑ Bloating	❑ Vomiting
	❑ Stomach cramps	❑ Diarrhea
	❑ Unable to pass gas	❑ Constipation
	❑ Vomiting blood	❑ Bright red blood from rectum
	❑ Blood in stool	
Neurological	❑ Headache	❑ Leg weakness
	❑ Confusion	❑ Leg numbness
	❑ Dizziness	❑ Fainting
	❑ Tingling	❑ Difficulty walking
Psychiatric	❑ Trouble sleeping	❑ Anxiety
	❑ Irritable	❑ Depression
Endocrine	❑ Hot flashes	❑ Muscle weakness
	❑ Night sweats	❑ General weakness

Blood/Lymph	❑ Swollen glands ❑ Swollen glands, neck ❑ Jaundice	❑ Easy bleeding ❑ Easy bruising
Urinary	❑ Pain when urinating ❑ Urinating often ❑ Urinary urgency ❑ Incontinence ❑ Pain in testicles	❑ Unable to start urinating ❑ Urinating a lot at night ❑ Blood in urine ❑ Pain in pelvis
Musculoskeletal	❑ Joint pain ❑ Muscle aches ❑ Back pain ❑ Limping	❑ Joint swelling ❑ Joint stiffness ❑ Spasms in back
Skin and Breasts	❑ Rash ❑ Sores ❑ Wound ❑ Itching ❑ Pain without rash or sore ❑ Mouth sores ❑ Breast lump	❑ Redness ❑ Swelling ❑ Scaling ❑ Blister ❑ Ulcer ❑ Breast pain

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Memory Disorder Clinic

PLEASE CHECK ALL PROBLEMS YOU HAVE NOTICED:

Orientation	❑ Time ❑ Place ❑ Person ❑ Family ❑ Gets lost/wanders ❑ Confusion/disorientation ❑ Confusion/agitation in afternoon/evenings ❑ Low level of awareness during the day	
Short Term Memory	❑ Recent events ❑ Names ❑ Faces ❑ Loses things ❑ Forgets where they are going ❑ Taking medicines ❑ Repeats questions or conversations ❑ Appointments	
Language	❑ Cannot understand what others say ❑ Cannot understand what they are reading ❑ Hard time finding words ❑ Hard time saying words ❑ Garbles/nonsense speech ❑ Difficulty expressing themselves in writing	
Motor	❑ Uncoordinated ❑ Balance problems ❑ Difficulty walking ❑ Poor dexterity	❑ Slow ❑ Drops things ❑ Falls, stumbles or trips ❑ Difficulty get in/out of chairs

Name: _____ DOB:_____

Continued on reverse side

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Attention/Concentration	❑ Distractible ❑ Rereads things ❑ Mind goes blank ❑ Can't focus during conversations ❑ Loses train of thought ❑ Difficulty paying attention	
Visual/perceptual	❑ Misses when reaching for things ❑ Runs into furniture/walls ❑ Gets lost driving ❑ Hits curbs when driving ❑ Car accidents	
Executive functions	❑ Planning or organization ❑ Task completion ❑ Judgment ❑ Problem solving ❑ Multi step tasks	
Activities of Daily Living	❑ Dressing ❑ Hygiene ❑ Walking ❑ Cleaning house ❑ Multi step tasks	❑ Cooking ❑ Shopping ❑ Driving ❑ Managing money
Emotions	❑ Depression ❑ Sadness, grief or loss ❑ Crying ❑ Loneliness ❑ Anger ❑ Withdrawal	❑ Irritable ❑ Lack of feeling ❑ Suicidal thoughts ❑ Paranoia ❑ Physical or verbal aggression ❑ Lack of interest in things

Do you drive? ❑ Yes ❑ No

If no, is this a change for you: ❑ Yes ❑ No

Reason:_____

_____

Are you interested in research projects with the Memory Disorder Clinic? ❑ Yes ❑ No

Name: _____ DOB:_____

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Consent to Release Information

Tallahassee Memorial Memory Disorder Clinic
Florida Department of Elder Affairs, ADI 1996

I understand that the records of my treatment are private and confidential. I understand that my records may be shared with the other care providers within the Tallahassee Memorial HealthCare system and the Department of Elder Affairs for the purpose of diagnosis, education, research and supervision. My records shall be available for auditing by the Department of Elder Affairs or its designee, but my records shall not be released further without my written consent or a court order.

Patient Name (handwritten): _____

_____ _____
Signature of Patient Date

_____ _____
Signature of Guardian Date