

Patient Id # _____

Texas Institute for Neurological Disorders

Patient Name: _____ **Date of Service:** ____ / ____ / ____

Mailing Address: _____ **D.O.B.:** ____ / ____ / ____

Email Address: _____

Phone Number: (____) _____ **Alt #** (____) _____

Your appt is with Dr : _____

Your primary care physician: _____ **Your Referring physician:** _____

Reason for visit today: _____

Medication List

We would be happy to copy your medication list if you have it with you. If not please list all medications below.

Medication Name	Dosage	Directions

Past Medical History

Please check any boxes if you have been diagnosed with any of the following condition(s)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> COPD	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Stroke	<input type="checkbox"/> Erectile dysfunction	<input type="checkbox"/> Seizures
<input type="checkbox"/> Lupus	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Liverdisease
<input type="checkbox"/> GERD	<input type="checkbox"/> Headache / Migraine	<input type="checkbox"/> Bipolar disease
<input type="checkbox"/> Irritable bowel syndrome	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Heart disease
<input type="checkbox"/> Cholesterol problems	<input type="checkbox"/> Deep Vein Thrombosis	<input type="checkbox"/> Depression
<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Neuropathy
<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Huntington’s disease	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Other (Please list)	<input type="checkbox"/> Other (Please list)	<input type="checkbox"/> Other (Please list)

Are you allergic to any medications? No Yes, please list _____

Past Surgical History

Month and Yr of Surgery	Type of Surgery

Family History

(If a family member has a history of any of the diagnoses below, please check box under appropriate box.)

Disease	Mother	Father	Maternal Grand Father	Paternal Grand Father	Maternal Grand Mother	Paternal Grand Mother	Siblings
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinsons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: (please list)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History

Marital status	Work status	Have you had a drink containing alcohol in the past year ?	Do you Smoke?	Have you ever been addicted to drugs?	Do you consume caffeine on a daily basis?
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Retired	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>Please answer questions below</i> <input type="checkbox"/> N/A and/or Minor	<input type="checkbox"/> Never smoked <input type="checkbox"/> Current smoker <input type="checkbox"/> Former smoker <i>Please answer questions below</i> <input type="checkbox"/> N/A and/or Minor	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A and/or Minor	<input type="checkbox"/> No <input type="checkbox"/> Yes, 1-2 cups/day <input type="checkbox"/> Yes, 3-4 cups/day <input type="checkbox"/> Yes, 5+ cups/day

If you answered Yes to "Have you consumed alcohol" please answer the following questions:

In the past year how often have you had a drink? Monthly or less 2-4 per mth 2-3 per wk 4+ per wk

How many did you have when you did drink in the past year? 1-2 3-4 5-6 7-9 10+

How often in the past year did you have 6 or more drinks at one time? Never Less then monthly Monthly
 Weekly Daily

If you checked current smoker please answer the following questions:

How often do you smoke cigarettes? Daily Some days, not every day

How many cigarettes do you smoke per day? 5 or less 6-10 11-20 21-30 31 or more

How soon after waking do you smoke? within 5 min 6-30 min 31-60 min after 60 min

Are you interested in quitting? Ready to quit Thinking about quitting Not ready to quit

If you checked former smoker please answer the following questions:

How long has it been since you last smoked: less then 1 mth 1-3 mths 3-6 mths 6-12 mths
 1-5 yrs 5-10 yrs over 10 years