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)

□ Diabetes	□ COPD	□ Kidney disease
□ Stroke	□ Erectile dysfunction	□ Seizures
□ Lupus	□ Osteoarthritis	□ Hypertension
□ Asthma	□ Fibromyalgia	□ Liverdisease
□ GERD	□ Headache / Migraine	□ Bipolar disease
□ Irritable bowel syndrome	□ Thyroid problems	□ Heart disease
□ Cholesterol problems	□ Deep Vein Thrombosis	□ Depression
□ Sleep Apnea	□ Rheumatoid Arthritis	□ Neuropathy
□ Muscular Dystrophy	□ Huntington's disease	□Multiple Sclerosis
□ Other (Please list)	□ Other (Please list)	□ 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	☐	☐	☐	☐	☐	☐	☐
Headache	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Parkinsons	☐	☐	☐	☐	☐	☐	☐
Alzheimers	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐
Other: (please list)	☐	☐	☐	☐	☐	☐	☐

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?
□ Single □ Married □ Divorced □ Widowed □ N/A	□ Yes □ No □ Student □ Disabled □ Retired	□ No □ Yes *Please answer questions below* □ N/A and/or Minor	□ Never smoked □ Current smoker □ Former smoker *Please answer questions below* □ N/A and/or Minor	□ Yes □ No □ N/A and/or Minor	□ No □ Yes, 1-2 cups/day □ Yes, 3-4 cups/day □ 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 <u>current</u> 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 <u>former</u> 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