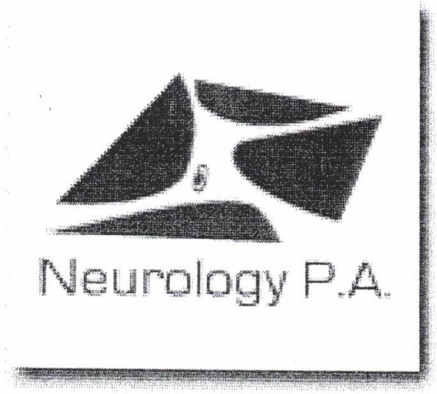

ADDRESS: 4161 TAMIAMI TRAIL SUITE 201

PORT CHARLOTTE, FLORIDA 333952

PHONE NUMBER: (941) 764-0800

FAX NUMBER: (941) 764-6494

WELCOME TO NEUROLOGY PA

PLEASE BRING INSURANCE CARDS, DRIVER'S LICENSE, PRESCRIPTION CARDS ALONG WITH A MEDICATION LIST

TO PROVIDE BETTER SERVICE, PLEASE BRING WITH YOU OR ARRANGE TO DELIVER TO US ALL YOUR LABORATORY TESTS, MRI'S & CT SCANS

PLEASE BRING COPIES OF HEALTH CARE SURROGATE, POWER OF ATTORNEY OR LIVING WILL

WE DO NOT PARTICIPATE IN PERSONAL INJURY, WORKERS COMPENSATION OR ACCIDENT-RELATED INSURANCES. IF YOU HAVE A CASE, YOU WILL BE RESPONSIBLE FOR EXPENSES FOR ANY TREATMENT RELATED TO THE INJURY

I HAVE AN APPOINTMENT WITH: Dr. Montoya:_____ Dr. Li: ____

NAME: _____ DOB: _____ SEX: _____

RACE: _____ PREFERRED LANGUAGE: _____

SOCIAL SECURITY: _____

E-MAIL ADDRESS: _____

LOCAL ADDRESS: _____

NORTHERN ADDRESS: _____

PHONE NUMBER: HOME: _____ CELL: _____ WORK: _____

MARITAL STATUS: _____

NAME OF THE SPOUSE/SIGNIFICANT OTHER _____

EMERGENCY CONTACT PERSON: _____

RELATION: _____ PHONE NUMBER: _____

ADDRESS: _____

HEALTHCARE SURROGATE/POA/LIVING WILL: _____

PHONE NUMBER: _____

ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____

REFERRING PHYSICIAN: _____

PREFERRED LOCAL PHARMACY: _____

MAIL ORDER PHARMACY: _____

PREFERRED LABORATORY FACILITY: _____

PREFERRED IMAGING FACILITY: _____

NAME: _____ DOB: _____

REASON FOR VISIT TODAY: _____

FAMILY HISTORY:

MOTHER: Alive _____Dead (Age) _____ Medical problem _____

FATHER: Alive _____Dead (Age) _____ Medical problem_____

OTHER: Alive _____Dead (Age) _____ Medical problem_____

SOCIAL HISTORY

TOBACCO SMOKING: NEVER _____ FORMER _____ CURRENT EVERYDAY _____

HOW MANY CIGARRETTES: _____PER DAY

SMOKELESS TOBACCO: NEVER _____ FORMER _____ CURRENT EVERYDAY _____

TOBACCO-YEARS OF USE: _____

E-CIGARRETTE/VAPE : NEVER _____ FORMER _____ CURRENT EVERYDAY _____

LIVE ALONE: _____ WITH OTHERS: _____

HAND DOMINANCE: RIGHT_____ LEFT _____AMBIDEXTROUS _____

DIET: REGULAR ____ VEGETERIAN ____ VEGAN ____ OTHER _____

GENERAL STRESS LEVEL: LOW_____ MEDIUM_____ HIGH_____

EXERCISE LEVEL: NONE ____ OCCASIONAL_____ MODERATE/HEAVY _____

CHEWING TOBACCO: NONE_____ YES_____ HOW MANY PER DAY_____

ALCOHOL INTAKE: NONE _____ OCCASIONAL ____ MODERATE____ HEAVY_____

CAFFEINE INTAKE: NONE _____ OCCASIONAL ____ MODERATE____ HEAVY_____

ADVANCE DIRECTIVES: YES_____ NO_____

SUBSTANCE ABUSE: YES_____ NO_____

CURRENTLY PREGNANT: YES_____ NO_____

DIFFICULTY CONCENTRATING, REMEMBERING OR MAKING DECISIONS: YES____NO____

ACCIDENT-RELATED INJURY: YES_____ NO_____

WE DO NOT PARTICIPATE IN PERSONAL INJURY, WORKERS COMPENSATION OR ACCIDENT-RELATED INSURANCES. IF YOU HAVE A CASE, YOU WILL BE RESPONSIBLE FOR EXPENSES FOR ANY TREATMENT RELATED TO THE INJURY

NAME: _____ DOB: _____

SURGICAL HISTORY:

YEAR	SURGERY

MEDICAL HISTORY:

__ Acid reflux (GERD)
__ Anemia
__ Aneurysm
__ Arthritis
__ Autoimmune disease
__ Back/ neck problems
__ Bleeding disorder
__ Brain tumors
__ Cancer
__ Cerebral palsy
__ Congenital disease
__ Coronary disease
__ Dementia
__ Depression
__ Diabetes
__ Epilepsy/ seizures
__ Fibromyalgia
__ Head trauma
__ Headache/ migraines
__ Heart disease
__ High Cholesterol
__ Hypertension
__ Kidney disease
__ Liver disease
__ Lung disease
__ Multiple sclerosis
__ Neuropathy
__ Sleep disease
__ Parkinson's disease
__ Stroke
__ Thyroid problems
__ Vertigo
__ Visual problems
__ Other_____
_____
_____

PLEASE LIST ALL THE MEDICATIONS YOU ARE TAKING

MEDICATION	DOSE	TIMES A DAY

NAME: _____ DOB: _____

PLEASE CHECK ALL THE SYMPTOMS THAT YOU HAVE HAD RECENTLY:

CONSTITUTIONAL
___Fever
___Night sweats
___Weight gain
___Weight loss
___Exercise intolerance
___Chills
___Malaise

EYES
___Dry eyes
___Irritation
___Vision change
___Eye disease/injury

ENMT
___Difficulty hearing
___Ear pain
___Frequent nose bleeds
___Nose problems
___Sinus problems
___Sore throat
___Bleeding gums
___Snoring
___Dry mouth
___Oral abnormalities
___Mouth ulcers
___Teeth problem
___Ringing in the ears
___Oral abnormalities

CARDIOVASCULAR
___Chest pain on exertion
___Arm pain on exertion
___Shortness of breath when laying down.
___Palpitations
___Known heart murmur.
___Lightheaded on standing
___Ankle swelling.

RESPIRATORY
___Cough
___Wheezing
___Shortness of breath
___Coughing up blood.
___Sleep apnea

GASTROINTESTINAL
___Abdominal pain
___Nausea
___Vomiting
___Constipation
___Change in appetite
___Frequent diarrhea
___Vomiting blood
___Dyspepsia
___GERD

GENITOURINARY
___Incontinence
___Difficulty urinating
___Increase frequency.
___Hematuria

MUSCULOSKELETAL
___Muscle aches
___Muscle weakness
___Arthralgias/joint pain
___Back pain
___Swelling in extremities.
___Neck pain
___Difficulty walking
___Cramps
___Osteoporosis
___Fractures

INTEGUMENTARY
___Abnormal mole
___Jaundice
___Rash
___Itching
___Nonhealing areas
___Changes in hair/nails
___Psoriasis
___Change in skin color
___Breast lump

NEUROLOGIC
___Loss of consciousness
___Weakness
___Numbness
___Seizures
___Dizziness
___Headaches
___Migraines
___Restless legs
___Tremor
___Gait dysfunction
___Paralysis

PSYCHIATRIC
___Depression
___Sleep disturbances
___Feeling unsafe in relationship.
___Alcohol abuse
___Anxiety
___Hallucinations
___Suicidal thoughts
___Mood swings
___Memory loss
___Agitation
___Dementia
___Delirium

ENDOCRINE
___Fatigue

HEMATOLOGIC/ LYMPHATIC
___Swollen glands
___Easy bruising
___Excessive bleeding
___Anemia
___Phlebitis

ALLERGIC/ IMMUNOLOGIC
___Runny nose
___Sinus pressure
___Itching
___Hives
___Frequent sneezing