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: (Check one)** ☐ ***Dr. Sundaram Jr*** ☐ ***Dr. B. Sundaram*** ☐***Dr. Matus*** ☐***Dr. Lopez***

☐ ***Dr. Al-Rifai*** ☐ ***Dr. Morales*** ☐ ***Dr. Mayakrishnan*** ☐ ***Dr.Trinidad*** ☐ ***Dr. Thirunarayanan*** ☐ ***Dr. Ali***

☐ ***Dr. Trinidad*** ☐ ***Dr. Tank*** ☐ ***Dr. Khalid*** ☐ ***Dr. Wang*** ☐ ***Kamau, NP*** ☐ ***Desai, NP***

**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 |
|---|---|---|
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## 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 | ☐ Liver disease |
| ☐ 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<br>☐ Married<br>☐ Divorced<br>☐ Widowed<br>☐ N/A | ☐ Yes<br>☐ No<br>☐ Student<br>☐ Disabled<br>☐ Retired | ☐ No<br>☐ Yes<br>*Please answer questions below*<br>☐ N/A and/or Minor | ☐ Never smoked<br>☐ Current smoker<br>☐ Former smoker<br>*Please answer questions below*<br>☐ N/A and/or Minor | ☐ Yes<br>☐ No<br>☐ N/A and/or Minor | ☐ No<br>☐ Yes, 1-2 cups/day<br>☐ Yes, 3-4 cups/day<br>☐ 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