Florida Medical Clinic
Your Life, Our Specialty

FLORIDA MEDICAL CLINIC
NEUROLOGY TAMPA

Edmund G. Grant, M.D.
Diplomat American Board of Psychiatry and Neurology

NEW PATIENT HISTORY

Name _____ Date _____

Referring Physician _____

Please list hospitalizations and surgeries:

Please list your current medications:

Name of type of medication	Dose	Frequency

Are you allergic to any medications? Which ones?

Please check if **YOU PERSONALLY** have had any of the following:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bad Heart Valve
- ☐ Blood Clots
- ☐ Cancer
- ☐ Colitis or Crohn's
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Kidney Disease, Nephritis
- ☐ Rheumatoid Arthritis
- ☐ Sickle Cell
- ☐ Stroke
- ☐ Syphilis
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Ulcers

Family History

Please check if **SOMEONE IN YOUR FAMILY** has had any of the following:

- ☐ Alcohol Abuse
- ☐ Alzheimers
- ☐ Brain Aneurysm
- ☐ Brain Tumor
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Abuse
- ☐ Headaches
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Mental Retardation
- ☐ Muscular Dystrophy
- ☐ Neurofibromatosis
- ☐ Neuropathy
- ☐ Numbness in Feet
- ☐ Psychiatric Illnesses
- ☐ Seizures
- ☐ Stroke

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Name _____ Date _____

Review of Systems: Please check if **YOU PERSONALLY** are experiencing any of the following:

CONSTITUTIONAL
☐ Fevers
☐ Chills
☐ Sweats
☐ Weight Loss

EYE
☐ Double Vision
☐ Sudden Loss of Vision

EAR, NOSE, MOUTH, THROAT
☐ Difficulty Swallowing
☐ Nose Bleeds
☐ Deafness

ALLERGY
☐ Chronic Cough
☐ Chronic Runny Nose
☐ Chronic Sneezing

CARDIOVASCULAR
☐ Irregular Heartbeat
☐ Chest Pain
☐ Fainting
☐ Swollen Ankles

PULMONARY
☐ Wheezing
☐ Coughing up Blood

GI
☐ Difficulty Swallowing
☐ Nausea
☐ Vomiting Blood
☐ Diarrhea, Colitis
☐ Incontinent of Stool
☐ Blood in Stool

GU
☐ Incontinent of Urine
☐ Blood in Urine
☐ Bladder Infection Now

WOMEN
☐ Pregnant Now
☐ Might be Pregnant

MEN
☐ Erectile Dysfunction

BLOOD, LYMPHATIC
☐ Blood Clots
☐ Taking Blood Thinners

BONES, MUSCLES
☐ Joint Pain
☐ Muscle Pain

SKIN
☐ Rash
☐ Sores

ENDOCRINE
☐ Abnormal Hair Loss
☐ Abnormal Hair Growth
☐ Excessive Thirst
☐ Excessive Urination

MOOD
☐ Mood Swings
☐ Anxiety
☐ Panic Attacks
☐ Hallucinations
☐ Violent Tendencies

Social History:

Do you drink alcohol? How often? ☐ Never or hardly ever ☐ Occasionally
☐ More than 3 drinks per day ☐ I have had seizures, rum fits, blackouts, DT's, or DUI's

Do you use tobacco regularly? ☐ No, or quit more than 10 years ago ☐ Chew tobacco
☐ Smoke pipe or cigar ☐ Smoke cigarettes

Is there a history of drug abuse? ☐ None ☐ Cocaine or amphetamines
☐ Valium or sedatives ☐ Narcotics ☐ Intravenous drug use

How much caffeine do you use? ☐ None ☐ Up to two beverages per day
☐ More than two beverages per day

How much acetaminophen (Tylenol, Anacin, Excedrin, BC, Goody) do you use?
☐ Less than once a week ☐ More than once a week ☐ Every day

What is the highest level of education you have attained? _____

Are you married at present? ☐ Yes ☐ No If yes, year you got married? _____

Are you right or left handed? _____

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CORTICAL FUNCTION EXAM

Patient Name _____

Draw a map of Florida - Mark locations of Tampa, Jacksonville and Miami:

Write a sentence:

Draw a clock:

Draw a cube: