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:

<table>
<thead>
<tr>
<th>Name of type of medication</th>
<th>Dose</th>
<th>Frequency</th>
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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
- □ Drug Abuse
- □ Neurofibromatosis
- □ Alzheimers
- □ Headaches
- □ Neuropathy
- □ Brain Aneurysm
- □ Heart Disease
- □ Numbness in Feet
- □ Brain Tumor
- □ High Blood Pressure
- □ Psychiatric Illnesses
- □ Depression
- □ Mental Retardation
- □ Seizures
- □ Diabetes
- □ Muscular Dystrophy
- □ Stroke
- □ Dizziness
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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? __________________
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: