Name: ____ Birth Date: ___________ Date: _____________
Reason for you visit today? ____

Preferred Pharmacy: ___________________________________	Preferred Lab: ____
Please list current medication:	Please list all the health-related issues you have been diagnosed:

Have you ever had Sexually transmitted disease or HPV? (HIV/ AIDS including Chlamydia, gonorrhea syphilis): ______________________________	Do you have a Numbness anywhere? Yes ☐ No ☐ Describe Where: ___________________________________	Are you taking any anticoagulant agents (e.g.: Coumadin, plavix, aspi☐n): Yes ☐ No ___________________________________

Please list all surgeries:	Are you allergic to:
	Aspirin ☐ Penicillin ☐ Codeine ☐
	Sulfa Drugs ☐ Morphine ☐ X-ray dye ☐
	Any other allergy which is nor listed above:

Family Medical History

	Age:	Disease	If deceased cause of death
Father	________	______________________________	___________________________
Mother	________	______________________________	___________________________
Siblings	________	______________________________	___________________________
Paternal Grandmother	________	______________________________	___________________________
Paternal Grandfather	________	______________________________	___________________________
Maternal Grandmother	________	______________________________	___________________________
Paternal Grandfather	________	______________________________	___________________________
Spouse	________	______________________________	___________________________

Are you under another doctor's care? Yes ☐ No ☐

Dr's Name	For What Reason?
Dr's Name	For What Reason?
Dr's Name	For What Reason?

We realize that time is as important to you as it is to us. We adhere to our appointment schedule as closely as possible. However, due to the unpredictable nature of medical care, unexpected delays may occur. We trust that you will understand.

Authorization to Release Information & Assignment of Benefits: I hereby authorize the release of any medical information required in the course of my treatment necessary to process insurance claims. I also authorize payment of medical benefits to Sunshine Neurology PA., for medical services rendered in the course of my treatment. I understand that I am personally responsible for payment in full for all expenses incurred as a result of services rendered. I have provided the above information to the best of my knowledge. Also read and understood the office policy. The above information is true to the best of my knowledge.

____ ______________________

Patient/Guardian signature Date

Name: ____ Birth Date: __________ Date: ____________
Reason for you visit today? ____

Social History

Do You Smoke? Yes ☐ No ☐	Are you a tobacco user? Yes ☐ No ☐
If yes: please check your response below: Current Smoker ☐ Former Smoker ☐	Do you use an illicit drug other than prescription drugs? Yes ☐ No ☐ If yes please list the type of drugs you have used? ____
If current smoker how often, you smoke? Everyday ☐ Someday ☐	Have you had drink containing alcohol in the past year? Yes ☐ No ☐ If yes: How often do you drink alcohol: Never ☐ 2 to 4 times a month ☐ 4 or more times a week ☐ Monthly or less ☐ 2 to 3 times a week ☐
How many cigarettes a day? _____	
How soon after you wake up do you smoke your first cigarette? Within 5 minutes ☐ ☐ 6-30 minutes 31-60 minutes ☐ after 60 minutes ☐	How many drinks did you have on a typical day when you were drinking? 1-2 drink ☐ 3-4 drinks ☐ 5-6 drinks ☐ 7-9 drinks ☐ 10 or more drinks ☐ How often did you have 6 or more drinks? Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐
Are you interested in quitting? Ready to quit ☐ thinking about quitting ☐ not ready to quit ☐	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

I authorize discussion of my general medical condition and diagnosis (including treatment, payment, and medical operations) with: Spouse ☐ Children ☐ other ☐

Name(s): ________________________________ Name(s): ____________________________________

I, _________________________________, authorize Sunshine Neurology PA to download my prescription history from RXHub which includes most major pharmacies. This is a valuable tool used by the physician in this practice to obtain all of your recently prescribed medication that was filled at the pharmacy. This helps to avoid drug interactions and possible unwanted mixtures of certain medication.

______________________________________ ________________________________

Patient Signature Date