# **New Patient Form- Multiple Sclerosis**

Name:	Age:	_ Date of Visit:		
Date of Birth: Refe	erring Physician	:		
Primary Care Physician:				
Main Reason for Visit Today:				
Email Address:		Phone Number:		
Phone Type:	Pharmacy Name	e/Location:		
Check if you have past medical history of the following:	Yes	Current 1	Medications:	
Arthritis		Name	Dose	Frequency
Cancer				
High cholesterol				
Depression				
Diabetes				
Heart rhythm problems				
Heart attack				
High blood pressure				
HIV/AIDS	<u> </u>			
Hepatitis				
Lung/pulmonary disease				
Memory loss				
Migraine headaches				
Recurrent infections				
Seizure				
Stroke				
Social History: Martial status: S/M/D/W Occupation:  Children: Yes/No Tobacco: Yes/No Quit? Yes/No W Alcohol: Yes/No Frequency? Drug use? Yes/No	/hen?	edication Allergies:		
Highest Level of Education:				
Where were you born?				

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States/countries lived in:		
Past Surgeries:		
Date	Type of Surgery	

## Any recent or ongoing symptoms of the following: (Mark with an "X")

	Denies	Admits
Constitutional:		
Fever		
Chills		
Weight loss		
Fatigue		
Sweating		
Skin:		
Rash		
Skin cancer		
Itching		
Psoriasis		
Eczema		

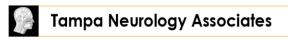
## Any recent symptoms of: (Mark with an "X")

	Denies	Admits
HENT:		
Headaches		
Hearing loss		
Ear ringing		
Ear pain		
Nose bleeds		
Congestion		
Eyes:		
Blurred vision		
Double vision		
Eye pain		
Macular degeneration		

	Denies	Admits
Cardiac:		
Chest pain		
Palpitations		
Leg swelling		
Hematologic:		
Anemia		
Bruising		
Bleeding		
<b>Respiratory:</b>		
Cough		
Sputum production		
Shortness of breath		

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Glaucoma	
Cataracts	
Eye discharge	
Eye redness	

Wheezing	

	Denies	Admits
<b>Gastrointestinal:</b>		
Reflux/GERD		
Nausea		
Vomiting		
Abdominal pain		
Diarrhea		
Constipation		
Blood in stool		
Musculoskeletal:		
Muscle aches		
Neck pain		
Muscle spasms		
Back pain		
Joint pain		
Falls		
Arthritis		
Psychiatric:		
Depression		
Suicidal ideas		
Hallucinations		
Nervous/anxious		
Insomnia		
Memory loss		

	Denies	Admits
Genitourinary:		
Pain with urination		
Urgency		
Frequency		
Blood in urine		
Waking up to		
urinate		
Catheterization		
Hesitancy to void		
<b>Endocrine:</b>		
Hypo-thyroid		
Hyper-thyroid		
Diabetes		
Neurologic:		
Dizziness		
Tingling		
Tremor		
Sensory changes		
Localized weakness		
Seizures		
Fainting		
Balance difficulty		

**Family Medical History:** 

	Alive/Dead	Cause of
		Death/Illnesses
Mother		
Father		
Sister(s)		
Brother(s)		
Maternal		
Grandmother		
Maternal		
Grandfather		

Circle if any	Multiple Sclerosis
known family	Rheumatoid arthritis
history of:	Crohn's disease
	Hashimoto's thyroiditis

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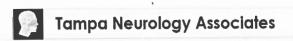


Paternal	
Grandmother	
Paternal	
Grandfather	
Other:	

If used, with approximate dates of use, and reasons for stopping (if applicable)

Avonex	
Betaseron/Extavia	
Copaxone/Glatiramer	
acetate	
Rebif	
Plegridy	
Tysabri	
Gilenya	
Mayzent	
Zeposia	
Aubagio	
Tecfidera	
Vumerity	
Lemtrada	
Ocrevus	
Rituximab	
Zinbryta	
Mavenclad/Cladribine	
Novantrone/Mitoxantrone	
Ampyra/Dalfampridine	
IVIG	
Cytoxan/Cyclophosphamide	

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#### Patient Health Questionnaire (PHQ-9)

Name:	Date:
Over the last two weeks, how often have	e you been bothered by any of the following
problems? Use an "X"	to indicate your answers.

	Not at All (0)	Several Days (1)	More than Half the Days (2)	Nearly Every Day (3)
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself or that you are a failure, or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people have noticed;				
or the opposite, being so fidgety or restless that you have been				
moving around a lot more than usual				
9. Thoughts that you would be better off dead or hurting yourself in some way				

**Total Score:** 

#### **Interpretation of Total Score for Depression Severity:**

- 1-4: Minimal depression
- 5-9: Mild depression
- 10-14: Moderate depression
- 15-19: Moderately severe depression
- 20-27: Severe depression

#### **Patient Consent and Authorization Form**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I acknowledge receipt of notice of privacy and authorize you to use and disclose my protected health information to, and inclusive of:

Disclose the patient's personal health information, treatment, billing, and payment. Disclose the patient's diagnosis for related lab and diagnostic centers where treatment is rendered as requested by Tampa Neurology Associates, LLC/Neuroscience Consultants, LLP.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment and health operations, but that Tampa Neurology Associates, LLC is not required to agree to the restrictions. However, if Tampa Neurology Associates, LLC/Neuroscience Consultants, LLP agree, you are then bound to comply with this restriction.

If I revoke this consent, Tampa Neurology Associates, LLC/Neuroscience Consultants, LLP does not have to provide any further healthcare services to the patient.

My signature below indicates that I have been given the chance to review a current copy of the Tampa Neurology Associates, LLC/Neuroscience Consultants, LLP Notice of Privacy Practices. This can be found at <a href="https://www.fcneurology.net">www.fcneurology.net</a> or can be provided upon request. My signature indicates that I agree to follow Tampa Neurology Associates, LLC/Neuroscience Consultants, LLP to use and disclose my personal health information to carry out treatment, payment and healthcare operations.

Signature:	Date:	
Financial Agreement/Assi	gnment of Benefits:	
for all fees, services and treatments insurance, this is payable by the and non-covered services. After cycle, it is subject to a monthly	be made directly to Tampa Neurology Associates, I ue to me from my insurance company. The responsion to the incurred by the patient. If there is a fee that is repatient. The patient also agrees to pay for all deduct receipt of a statement, if payment is not received a finance charge. If an account is referred to an outs of pay for all such action. An account will be referred to within 90 days of service.	sible parties agree to pay not covered by uctibles, co-payments by the next billing
Signature:	Date:	

**Print Patient Name:** 

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Relationship to Patient:

Name:	Date of Birth:	Gender:			
Home Address:	City:	State:			
Zip Code: Phone No	umber:	Email:			
Employer:	_ Address:				
Business Phone:	_				
Emergency Contact Name:	Relationship: _				
Phone Number:					
Primary Insurance: Insurance Company: Address: State: Zip Code: Policy Holder Name: Subscriber Name: Group Number:	Address: City: Zip Code: Policy Holder Na Subscriber Name	any:			
Workmen's Compensation: Were you injured on the job? Yes No Date:					
Employer: Insurance Company Responsible for Claim:					
Adjustor's Name: Address:					
City: State: Zip Code:					
Public Liability: Is this the result of an accident? Yes No Date:					
Attorney's Name:	Phone Number:				
Insurance Company Responsible for Claim:					
Name of Insured: Address of Insurance Company:					