Dear Patient,

In accordance with HIPPA

_____ _____

Marlene and Paolo Fresco Institute for Parkinson's and Movement Disorders

New Patient Intake Questionnaire

Name: _____ Appointment Date: _____

Date of birth: _____ Handedness: Right Left Ambidextrous

Who referred you to our center?

Name:_____ Address: _____

Phone number: ( ) _____ Fax number: ( )_____

Type of Doctor (if relevant): _____

Who is your internist, general doctor, or primary care provider ?

Name:_____ Address: _____

Phone number: ( ) _____ Fax number: ( ) _____

Type of Doctor (if relevant): _____

Demographics:

Occupation: _____ Name of employer: _____

Employment status (circle one): Working full time Working part-time Student
Short-term disability Long-term disability Retired

Highest grade level or degree(s):_____

Marital status (circle one): Single Married Separated
Divorced Widowed Domestic Partner

Spouse's/Domestic partner's name (if any): _____

How many children do you have?_____ Who lives at home with you? _____

In which country were you born? _____

Countries of your ancestors?_____

With the installation of Epic, the new electronic medical record system, at this practice, your doctor is now able to e- prescribe. This means that any prescriptions the doctor may give you today will be automatically routed to the pharmacy of your choice and we will no longer have to provide you with handwritten prescriptions. In addition, when you run out of refills on your medication, the pharmacist can now electronically send renewal requests to this office for approval.

Name of	
Address:	
City:	
State:	
Zip Code:	
Phone Number:	
Fax Number:	

LabCorp	
Quest Labs	
NYU Lab	

What is the major neurological problem that brings you to the office today?

Current Medications, Vitamins, and Supplements:

Please list the medication name, dose, and timing.

Examples: Carbidopa-Levodopa 25/100 mg, 2 tablets 5 times daily at 8-12-2-4-8
Melatonin 3 mg tablets, 1 tablet every evening

Medication:

Supplements:

Allergies :

Are you allergic to any medications, foods, or contrast dye? Yes No

What are you allergic to? What is your reaction? _____

Personal and Social History

Past Medical and Surgical History:
(If you provided this information online, please skip)

What medical