OHSU PARKINSON CENTER & MOVEMENT DISORDERS CLINIC

New Patient Appointment

BRAIN INSTITUTE
Oregon Health & Science University

➔ ⏱ ***Check in <u>15-minutes before</u> your appointment time.***
➔ 🗐 ***Complete all forms prior to your arrival.***

Patient Name: ______________________________

Patient DOB: ____________________ Age: ________

☐ Right-handed ☐ Left-handed

Primary Care Provider: ______________________
Phone: ______________________
☐ OHSU ☐ Other

Neurologist: ______________________
Phone: ______________________
☐ OHSU ☐ Other

Who is your primary contact and/or care partner?
☐ Spouse ☐ Adult Child ☐ Guardian ☐ Other Name: ______________________

➔ **Pharmacy Name:** ____________________ **Pharmacy Phone #:**____________________

✎ **IMPORTANT: LIST MEDICATIONS and DRUG ALLERGIES on the back.**

<u>SOCIAL HISTORY</u>

> Have you ever smoked or chewed tobacco?	☐ No	☐ Yes	Number of years: ________
> Do you drink alcohol?	☐ No	☐ Yes	Amount per week: ________
> Do you now or have you used any recreational drugs?	☐ No	☐ Yes	

<u>MEDICAL HISTORY</u> - Have you had a history of…. (circle all that apply)

Anemia	COPD	High Cholesterol	Stroke
Arthritis	Chronic Pain	HIV	TB
Asthma	Deafness	Hypertension	Thyroid Problems
Bleeding Disorder	Dementia	Menopause	Transfusions
Blindness	Depression	Nephrolithiasis	Vertigo / Dizziness
Coronary Artery Disease	Diabetes Mellitus	Peripheral Vascular Disease	
Cancer	Headache	Renal Failure	
Congestive Heart Failure	Hepatitis	Seizures	

<u>SURGICAL HISTORY</u> - Have you had a / an… (check all that apply & note <u>date</u> of procedure)

☐ Appendectomy	☐ Hysterectomy	☐ Thyroidectomy
☐ Back surgery	☐ Hernia repair	☐ Vasectomy
☐ Tubal ligation	☐ Knee arthroscopy	OTHER:
☐ Cataract removal	☐ Myringotomy	1.)
☐ Cholecystectomy	☐ Pacemaker replacement	2.)
☐ Colectomy	☐ Prostatectomy	3.)
☐ Cesarean section	☐ Splenectomy	4.)
☐ Hip replacement	☐ Tonsillectomy & adenoidectomy	5.)

(over)

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FAMILY HISTORY – Have any family members had the following neurological disorders:

Essential Tremor	Ataxia	Dystonia	
Parkinson's Disease	Huntington's Disease	Torticollis	Other: ___________________

DRUG ALLERGIES? ☐ No. ☐ Yes; please list:

MEDICATIONS and SUPPLEMENTS

Medication / Supplement	Dose (mg)	Instructions: *(and/or note time of day taken)*
		Example: 6a, 12p, 6p Take ____ pills, ____ times per day at:
		Take ____ pills, ____ times per day at:
		Take ____ pills, ____ times per day at:
		Take ____ pills, ____ times per day at:
		Take ____ pills, ____ times per day at:
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