GENESIS
Neuroscience Clinic

Patient Information Sheet

Today's Date: _____

Last:	First:	Middle:
Address:		Email:
City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:
Sex: □ Male □ Female	Date of Birth:	Social Security Number:
Ethnicity:	Language Preference:	Race:

Advanced Directives: Please mark if you have any of the following (Please bring copies to first appointment)

□ Healthcare Power of Attorney Name: _____	□ Living Will
□ DNR Form (Do Not Resuscitate)	□ Financial Power of Attorney

Primary caregiver information:

Name:	Relationship:
Address:	Email:
City:	State: Zip:
Home Phone:	Cell Phone:

1400 Dowell Springs Blvd, Suite 100 Knoxville, TN 37909
Phone: 865-888-9494 Fax: 865-444-7672

Billing Address:

□ Same as patient	□ Same as Primary caregiver
□ Other:	
Pharmacy (and Location) and Phone #:	
Primary Care Physician's Name:	
Address: City: State: Zip Code:	
Doctor's Phone Number:	Fax:
Names of Other Physician's Seen:	

Health Insurance

Primary Insurance Company	
Insured's Name and DOB	Insured's Soc. Sec. #
Relationship to Patient	□ Self □ Spouse □ Parent □ Other
Policy #	Group #

Secondary Insurance Company	
Insured's Name and DOB	Insured's Soc. Sec. #
Relationship to Patient	□ Self □ Spouse □ Parent □ Other
Policy #	Group #

Have you had a scan of your brain (CT or MRI)? □ Y □ N
If yes, date and location where it was performed. _____

Primary reason for your visit today:

_____
_____
_____

Family History:

Relative	Living?	Age	Illness/Cause of Death
Mother	□ Y □ N		
Father	□ Y □ N		
Brother	□ Y □ N		
Brother	□ Y □ N		
Sister	□ Y □ N		
Sister	□ Y □ N		
Children	□ Y □ N		
Children	□ Y □ N		

Is there any history of: **If so, who?**

Dementia: □ Y □N _____
Alzheimer's: □ Y □N _____
Memory Problem: □ Y □N _____
Parkinson's: □ Y □N _____

Is there a history of abuse?

Verbal □ Y □N
Sexual □ Y □N
Physical □ Y □N

Patient's Hospitalizations/Surgeries:

Date	Hospital	Type of Surgery/Reason for Hospitalization

Patient's Medical History: ***Please check all that apply***

□ Heart disease
□ Stroke
□ Parkinson's
□ Depression
□ Loss of Consciousness
□ High cholesterol
□ High Blood Pressure
□ Cancer
□ Seizure
□ Concussion
□ Head Trauma
□ HIV
□ Lyme's disease
□ Diabetes
□ Other, describe: _____

Allergies: □ No known allergies

Allergens	Reaction

Social History:

Marital status: □ Married □ Single □ Widowed □ Divorced
# of prior marriages_____
Spouse's name: _____
Spouse's health: _____
Do you have children? □ Y □ N How Many? _____
Are you or your spouse a veteran? □ Y □ N
List highest grade completed in school: _____
What is your current or former occupation? _____
Native language: _____Others spoken: _____
□ Right or □ Left handed

Do you currently smoke? □ Y □ N

If *yes*, How long have you been smoking? _____

How many packs a day do you smoke? _____

Did you quit smoking? □ Y □ N

If *yes*, When did you quit? _____

How many years did you smoke prior to quitting? _____

How many packs a day did you smoke? _____

Do you drink alcohol? □ Y □ N

If *yes*, What type, and how much per day? _____

Have you used alcohol in the past? _____

If *yes*, What type, and how much per day? _____

Did you ever use illicit drugs? □ Y □ N

Do you exercise regularly? □ Y □ N

Did you get a flu shot this year? □ Y □ N

Current Medications: Please bring all your prescription and non-prescription medications with you to this appointment **IN THE ORIGINAL BOTTLES.** Include eye drops, pills, nasal sprays, ointments, laxatives, herbals, supplements, vitamins, etc. Separate those that you use regularly from those that you only use as needed. List all medications you use regularly:

Medication Name	Dose/Strength	How Many? How many times per day?