Tri-State Mountain Neurology Associates, P.C.
1321 Sunset Drive, Suite 11
Johnson City, TN 37604
Phone: (423) 928-6174 Fax: (423) 926-2258

Patient Identifying Information

First Name: _____ Middle Initial: _____

Last Name: _____

Sex (Gender) ❍ Male ❍ Female

Date of Birth: _____/_____/_____
Month Day Year

Social Security No.: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone #: _____

Contact

Preferred method of communication: ❍ Email ❍ Phone ❍ Mail ❍ Not specified

Email: _____

Residential Phone: _____

Mobile phone: _____

Address

Number/Street/Suite: _____

City: _____

State: _____

Zip: _____ County: _____

Lives in a nursing home ❍ No ❍ Yes

Demographics

Race(s): ❍ White ❍ Black ❍ American Indian
❍ Hispanic ❍ Middle Eastern ❍ Japanese
❍ Chinese ❍ Other _____

Ethnicity: ❍ Non-Hispanic or Latino
❍ Hispanic or Latino ❍ Other

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Please List All Medical History	
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	

	Please List Surgical History	Date
(1)		
(2)		
(3)		
(4)		
(5)		

Family Medical History	
Mother	
Father	
Brother(s)	
Sister(s)	
Grandparents	

Please List Your Allergies Below

		Check Severity			Describe Reaction
	Name of Substance	**Mild**	**Mod**	**Severe**	**(rash, nausea, swelling, etc.)**
(1)					
(2)					
(3)					
(4)					
(5)					

	____Ft ___In	Weight	_____ pounds

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Please List All of Your Medications
(including non-prescription and other over-the-counter preparations)

❒ None ❒ See attached sheet ❒ See list below

	Name of Medication	Dose	Frequency
(1)			
(2)			
(3)			
(4)			
(5)			
(6)			
(7)			
(8)			
(9)			
(10)			
(11)			
(12)			
(13)			
(14)			
(15)			

Please Describe Any Advance Directives:
(For example: Power of attorney, living will, etc.)

OTHER INFORMATION THAT MAY BE IMPORTANT FOR YOUR PHYSICIAN:

_____
_____
_____
_____
_____
_____

Social History

Do you use?

Tobacco: ❒ No / ❒ Yes How Long: ____ Pks/Day ____ ❒ Quit / ___ # of yrs
Alcohol: ❒ No / ❒ Yes ❒ Beer: ___ cans/day ❒ wine: ___ glasses/day
❒ Liquor: ___ oz/day ___ # of yrs
Street drugs: ❒ No / ❒ Yes ❒ In the past Type(s)_____ How Often: _____
Caffeine: ❒ No / ❒ Yes ❒ Coffee _____cups/day ❒ Soft Drinks: _____ oz/day

Are you: ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed
Education: ❒ High School ____ years ❒ College ____ years ❒ Post Graduate ____ yrs

Occupation: _____ ❒ Retired ❒ Disabled
Employer: _____

Do you Drive: ❒ No / ❒ Yes

Epworth Sleep Scale

SITUATION	**CHANCE OF DOZING**
Sitting and Reading	_____
Watching TV	_____
Sitting inactive in a public place	_____
Being a passenger in a motor vehicle for an hour or more	_____
Lying down in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch (no alcohol)	_____
Stopped for a few minutes in traffic while driving	_____
TOTAL SCORE (add score up)	_____

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze or sleep
1 = slight chance of dozing or sleeping
2 = moderate chance of dozing or sleeping
3 = high chance of dozing or sleeping

I understand the importance of a truthful Health History to assist the doctor in providing the safest care possible. I have answered all of the above information accurately.

_____ (Patient signature)

_____ (Signature of other person filling out for the patient)