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 #: ____

Primary Care Physician: ____

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)