NEUROSURGERY OF WEST FLORIDA

Amir A. Ahmadian, MD
Suzanne Newby, PA
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New Patient Information Sheet

Patient Name: _____ Date: _____

Primary Care Physician: _____ Referring Physician: _____

Occupation: _____

Reason for your visit: _____

Symptoms:

When did symptoms begin: _____

When does the pain/problem occur (i.e.: morning/night) _____

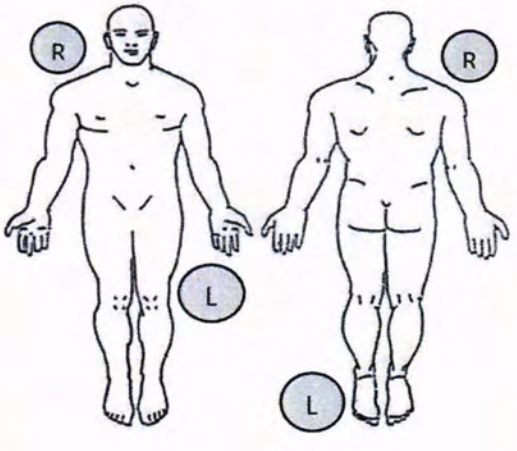
What aggravates the symptoms: _____

What reduced the symptoms: _____

Please check if you have other symptoms:

Symptom	Occurrence		Location
☐ Numbness	☐ Constant	☐ Intermittent	
☐ Pins/Needles/Tingling	☐ Constant	☐ Intermittent	
☐ Sharp Pain	☐ Constant	☐ Intermittent	
☐ Dull/Achy Pain	☐ Constant	☐ Intermittent	

Shade the areas you have



Shade the areas you have pain

7529 Medical Drive • Hudson, FL 34667 • Office: 727-862-6524 • Fax: 727-862-6439

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Rate Your Pain: Pain Scale 0 = No Pain 10 = Severe Today: ____ Last Week: ____

Types of Therapy	Effect on your Symptoms	Month/Year
☐ Physical Therapy	☐ Better ☐ Worse ☐ No Change	
☐ Nerve Blocks	☐ Better ☐ Worse ☐ No Change	
☐ Medication Use	☐ Better ☐ Worse ☐ No Change	
☐ Chiropractor	☐ Better ☐ Worse ☐ No Change	
☐ Other	☐ Better ☐ Worse ☐ No Change	

Current Medications: List all medications you are taking, including over the counter and vitamins.

☐ No medications

Name	Dose/Mg	Frequency	Name	Dose/Mg	Frequency

Allergies: List all known allergies to medications, food and latex.

☐ No known drug allergies

Name	Reaction	Name	Reaction

Medication History: List all medical problems for which you are currently being treated for.

☐ No Medical History

Medical Problem	Medical Problem

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Surgical History: List all surgical procedures and year.

☐ No Surgeries

Year	Procedure

Year	Procedure

Social History: Circle yes or No

Alcohol Use: Yes or No ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

Tobacco Use: Yes or No _____ Packs per day for _____ # of years.

Quit smoking _____ years ago.

Street Drug Use: Yes or No

Type: _____ Frequency: _____ Date of last use: _____

Caffeine Use: Yes or No Soda/Coffee/Tea _____ Cups daily

Weight: _____ Height: _____

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