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

Next of Kin Information:

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

1400 Dowell Springs Blvd, Suite 340 Knoxville, TN 37909
Phone: 865-888-9494 Fax: 865-444-7672

Billing Address:

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

If you would like to receive reminders and/or confirmation regarding appointments, prescription refills or other information, **please note your preferred method of communication**. You may choose more than one. ❑ Voice Messages ❑ Email

I authorize Genesis Neuroscience Clinic to disclose my protected health information to the following family/ non-family member(s): ❑ Patient only

_____ Ph #: _____

_____ Ph #: _____

_____ Ph #: _____

I authorize the practice to disclose only the following protected health information to the individual(s) listed above:

_____ Test results, reports, and general health updates

_____ Appointment information only

Have you had any of the following brain/head scans: ❑ CT ❑ MRI ❑ PET ❑ N/A

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		

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
- ☐ Other:_____
- ☐ High cholesterol
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Seizure
- ☐ Concussion
- ☐ Head Trauma
- ☐ HIV
- ☐ Lyme's disease
- ☐ Diabetes

Allergies: ☐ No known allergies

Please list any known allergies and reactions: _____

_____

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?

Social History:

Do you have children? ☐ Y ☐ N How Many? _____

Are you or your spouse a veteran? ☐ Y ☐ N

Highest grade completed in school: _____

What is your current or former occupation? _____

Native language: _____ Others spoken: _____

Right or Left Handed? ☐ Right ☐ Left

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

Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

# of prior marriages_____

Spouse's name: _____

Spouse's health: _____