

Padma R. Mahant, M.D.
 New Patient Information Sheet/ Annual Update
 Date: _____

Patient Name: _____ Date of Birth _____ Current Age _____

Home Phone: _____ Cell Phone: _____

Caregiver Name and Contact Info (If Applicable): _____ Phone _____

Primary Care Provider _____ Phone _____ Fax _____

Main Reason/Symptom for Appointment today: _____

1) Please list current medications: Please attach a separate sheet if necessary.

Medication Name	Strength(mg)	How many times per day?	Approx date/year started

PLEASE LIST ANY ALLERGIES:

Please circle any past medications that you are not currently taking, and please indicate reason for discontinuing the medication:

Sinemet IR or carbidopallevodopa	Sinemet CR	Comtan	Stalevo	Parcopa
Artane or trihexiphenid I	Mirapex	Mirapex ER	Requip	Requip XL
Apokyn	Amantadine	Artane	Midodrine	Florinef
Aricept	Exelon tab or patch	Namenda	Razadyne	Seroquel
Klonopin	Inderal	Topamax	Mysoline	Neurontin
Baclofen	Zanaflex	Depakote	Azilect	Zelapar or Selegiline
Phenergan	Compazine	Reglan	Haldol	Lithium

Reasons for discontinuing any of the above medications: _____

2) Please list any medical history:

Medical Conditions	Past Surgeries

3) Who do you live with? _____

4) Please list your occupation, current or former. If you are retired, please list the year you retired.

5) Do you currently smoke? Yes No
If you smoke now, or have in the past, how many packs per day? _____ For how many years? _____

6) Do you drink alcohol? Yes No If yes, how much per day or per week? _____

7) Have you experienced any of the following in the past 30 Days?

Tremor	Yes	No
Stiffness	Yes	No
Involuntary Movement	Yes	No
Difficulty w/ balance, walking	Yes	No
Memory Loss	Yes	No
Speech or Swallowing difficulty	Yes	No
Hearing Loss	Yes	No
Vision Trouble	Yes	No
Difficulty w/ daily activity	Yes	No
Weakness or Fatigue	Yes	No
Numbness or Tingling	Yes	No
Heartburn	Yes	No
Nausea or Vomiting	Yes	No
Depression or Anxiety	Yes	No
Vivid Dreams/Hallucinations	Yes	No
Skin Problems	Yes	No
Weight Loss	Yes	No
Fever	Yes	No
Chills, Sweats	Yes	No
Cough or Shortness of Breath	Yes	No
Chest Pain	Yes	No
Swelling of Feet	Yes	No
Compulsive Behaviors	Yes	No

List any other symptoms you are having: _____

I hereby authorize that the information that I have provided is correct and accurate to the best of my knowledge.

Signature: _____ Date: _____