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

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