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:

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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 carbidopa/levodopa	Sinemet CR	Comtan	Stalevo	Parcopa
Artane or trihexiphenidyl	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:____

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2) Please list any medical history:

Medical Conditions **Past Surgeries**

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3) Who do you live with? ______________________________

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

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5) Do you currently smoke? Yes or 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 or 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: ______________________________________

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

Signature: ______________________________ Date: ______________