UF UNIVERSITY of FLORIDA
The Foundation for The Gator Nation

UFHealth | FIXEL CENTER FOR NEUROLOGICAL DISEASES
Movement Disorders & Neurorestoration Program

Fixel Center for Neurological Diseases
Movement Disorders & Neurorestoration Program
Department of Neurology

3450 Hull Road, 4th Floor
Gainesville, FL 32607
(352) 294-5400
Fax: (352) 627-4295

Patient Appointment Confirmation

Patient name: ______________________________

At the request of your physician, you have been scheduled to see a Movement Disorder specialist with the University of Florida's Department of Neurology.

Your appointment date and time are as follows:

Date: ___________________

Time: ________________________

Physician: ___________________________

*****PLEASE BE SURE TO ARRIVE AT THE CHECK-IN DESK 30 MINUTES BEFORE YOUR VISIT. THE INTAKE PROCESS TAKES THE FULL 30 MINUTES AND IS VERY IMPORTANT TO YOUR VISIT!!!*****

*****PLEASE PLAN TO SPEND SEVERAL HOURS WITH US FOR YOUR EVALUATIONS, AS PHYSICIANS MAY REQUEST FOR YOU TO BE EVALUATED BY PHYSICAL, OCCUPATIONAL, AND/OR SPEECH THERAPY AND/OR YOUR APPOINTMENT MAY BE COORDINATED WITH OTHER APPOINTMENTS PERTAINING TO YOUR DIAGNOSIS*****

The following instructions are provided to help ensure that your new patient visit with our Center is as easy as possible for you. Please take a moment to read over them carefully:

1) Please visit us on the web at http://movementdisorders.ufhealth.org/new-patient-information. Here, you will be able to watch a short video which will welcome you to our Center and provide an introduction to our INFORM research database. Additionally, the site contains important information and instructions specific to your new patient visit with our Center. The new patient information form is also attached to this instruction packet for you to fill out and bring with you to the appointment.

2) Please ensure that you bring **ALL** prescription medications you are currently taking with you to your visit. Also, please ensure you have eaten prior to your visit. A current medication questionnaire is attached for you to fill out and bring with you to the appointment. We **do not** require patients to withhold food or drink prior to their visits with our Center.

Sincerely,

Your UF Health Movement Disorders Team

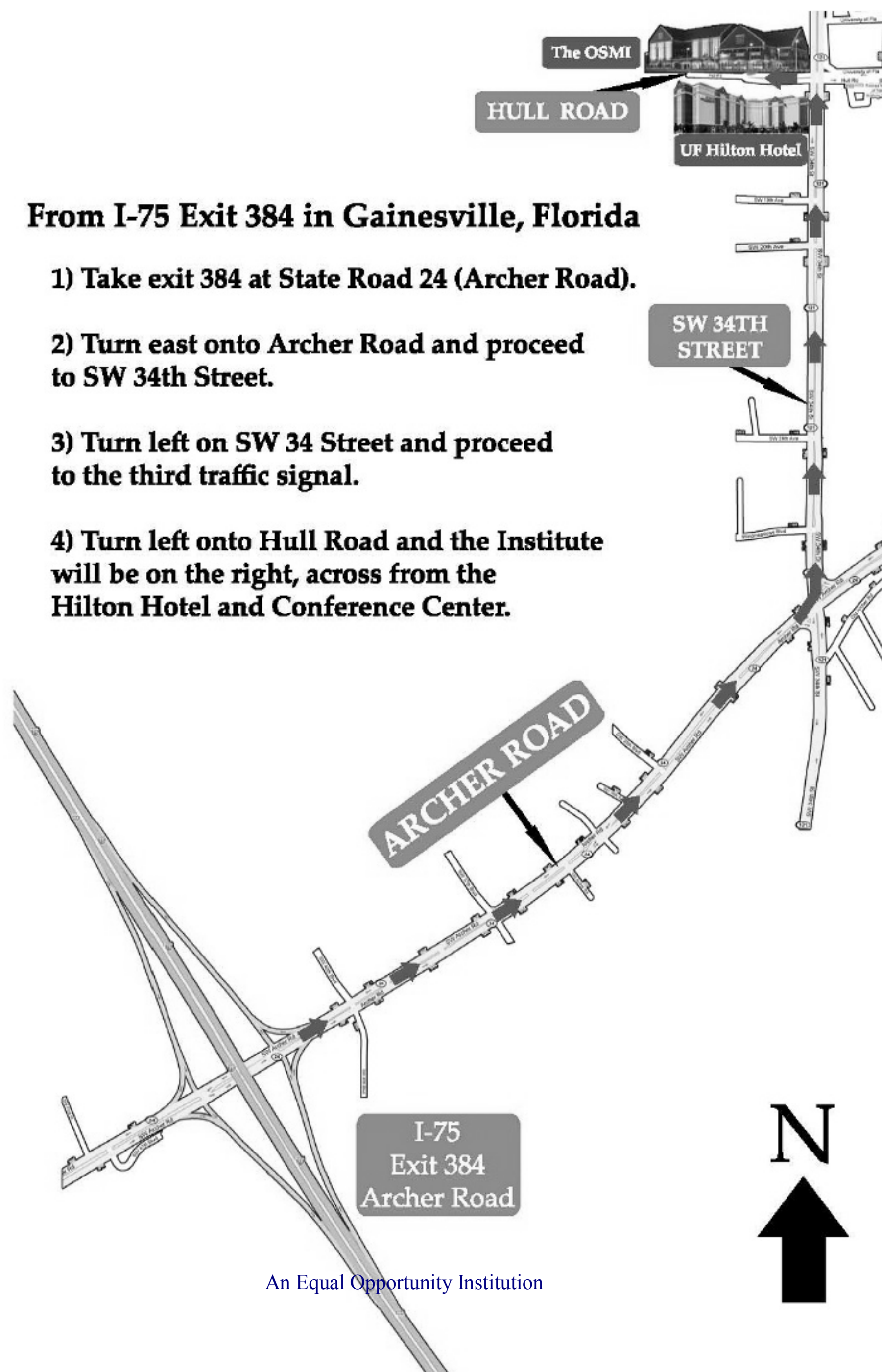
An Equal Opportunity Institution

Fixel Center for Neurological Diseases
Movement Disorders & Neurorestoration Program
at the Orthopedics and Sports Medicine Institute (OSMI)

3450 Hull Road, 4th Floor
Gainesville, FL 32607
(352) 294-5400
(352) 627-4295

The visitor parking lot for the OSMI is gated and is located immediately adjacent to the West side of the building. ***Parking is free with a voucher that you will receive at the end of your visit. Complimentary valet parking is also available at the front entrance.*** For patients with state-issued disability permits, there is handicapped parking along the front side of the building, facing SW 34th Street.

****Do NOT park in the rehab spaces marked with the *red & white* signs!!!****



Need help finding your way around UF Health?

Try Our Wayfinding Service!

A free service for neuromedicine patients that need help navigating UF Health.

Dial
(352) 327-8009
M-F 8 AM to 5 pm

Text/Call:
Your Name
Your Location
Your Destination

A volunteer will assist you to your next destination!

Remember:

Call/Text (352) 327-8009
M-F 8 AM to 5 PM
State Your: Name, Location, and Destination

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3450 Hull Road, 4th Floor
PO Box 112742
Gainesville, FL 32607
352-294-5400 Tel
352-627-4295 Fax

New Patient Appointment Information

We would like to welcome you to the Fixel Center for Neurological Diseases at UF Health's Movement Disorders & Neurorestoration Program. To help you prepare for your first visit with our clinic, please take a few moments to carefully review this information so that you will be better informed about what to expect at your new patient evaluation.

1) Please review the medication list at the bottom of this page. If you are taking any of these medications, please **STOP** these medications **at least 12 hours prior** to your first appointment and do not restart them until have been instructed to do so by our clinic.
   a. **If you are not taking any of the medications listed below, please continue to take your medications as directed by your local physician.**
2) Please ensure you bring your completed New Patient Information Form and Medication Questionnaire with you to your appointment. This will streamline your first visit and allow the physician more time to focus on the specific medical issue which has brought you to our Center.
3) Please bring **ALL** of your current medications with you to your visit.
4) Please come prepared to discuss the following:
   a. Past medications you have taken and why you stopped them.
   b. Past surgical procedures relevant to your movement disorder.
   c. Any family medical history that may be relevant to your movement disorder.
5) Please bring any additional relevant medical records or other examinations that your referring physician's office may not have sent us. Also, please make sure to bring the films and/or CDs from any relevant radiological studies (CT, MRI, X-ray, PET scan, etc.) that you have had done within the last **2 years**.

*Our staff is available to answer any questions you may have concerning your new patient evaluation. Also, we are happy to try and assist with some special arrangements if you will be in need of assistance during your visit. Please call **(352) 294-5400** to reach a member of our scheduling team.*

Due to the special nature of this evaluation, it is necessary for you to **STOP** any of the following medications for at least **12 hours prior** to your scheduled appointment time:

Carbidopa/Levadopa, Sinemet, Rytary, Neupro, Azilect, Adamet, Mirapex, Amantadine, Requip, Parlodel, Comtan, Stalevo, Parcopa, Apokyn, Zelapar, Tasmar. **If your medication is NOT listed, we cannot advise you to stop that medication prior to your visit. Please consult with your local physician.**

--SINEMET CR , SINEMET ER, MIRAPEX ER, and REQUIP XL--

These medications should be stopped **24-hours prior to your visit!!**

*****If you are coming for a two day evaluation and currently have a deep brain stimulator in place, please make sure you DO NOT restart any of the medications listed above until you have been instructed to do so by our clinic .*****

******You should take all other medications and eat a normal breakfast or lunch.******

UFHealth | FIXEL CENTER FOR NEUROLOGICAL DISEASES

Movement Disorders & Neurorestoration Program

New Patient Information Form

This form will help the doctor obtain information relevant to your care. Please fill out **both sides** as best you can.

Patient's name: ______________________________

Medical Record #: _____________ Date: _____________

Age: ________ Referring Physician: _________________

Our doctors will send a report to your referring physician.
Please indicate if you want a copy sent to someone else:

☐ Other Physician: ______________________

Address: ______________________________

City: _______________ State: _______ Zip: ________

☐ Yourself

☐ Other: ______________________________

Please state the main reason for this visit on the line below. Just state your main symptom(s) or concerns; for example, "headache" or "trouble walking." Do not include details of your history or testing. You will have ample opportunity to give the doctor the complete story. On the reverse side of this form, you can check off specific symptoms.

____

Medical History: Please check any diseases that you have had in the past or have now and the year of onset:

Disorder	Onset	Disorder	Onset	Disorder	Onset	Disorder	Onset
☐ Heart Disease	_____	☐ High Blood pres.	_____	☐ Lung disease	_____	☐ Thyroid disease	_____
☐ Atrial Fibrillation	_____	☐ High cholesterol	_____	☐ Asthma	_____	☐ Migraine	_____
		☐ Diabetes	_____	☐ Kidney failure	_____	☐ Sleep disorder	_____
☐ Blood clots	_____	On insulin? Yes No		Trauma		☐ Miscarriages	_____
☐ Stroke	_____	☐ Cancer	_____	☐ Head	_____	☐ Reflux (GERD)	_____
☐ Epilepsy	_____	*Location*	*Year*	☐ Neck	_____	☐ Fibromyalgia	_____
☐ Liver disease	_____	_________	_____	☐ Other	_____	☐ ADD/ADHD	_____
☐ Depression	_____	☐ Anxiety	_____	☐ OCD	_____		

Other Medical History: ____

Surgical History: Please check surgeries you have had and indicate year:

Surgery	Date	Surgery	Date	Surgery	Date	Surgery	Date
☐ Heart	_____	☐ Colon polyp	_____	☐ GI bypass/stapling (bariatric surg.)	_____	☐ Hip replacement	_____
☐ Bypass graft	_____	☐ C-section	_____			☐ Knee replacement	_____
☐ Stent	_____	☐ Gall bladder	_____	☐ Hernia	_____	☐ Cataract	_____
☐ Cancer *(fill in type)*		☐ Breast lump	_____	☐ Vasectomy	_____	*Other surgeries:*	
☐ _________	_____	☐ Appendix	_____	☐ Bladder	_____	☐ _________	_____
☐ _________	_____	☐ Tonsils	_____	☐ Brain	_____	☐ _________	_____
☐ _________	_____	☐ Hysterectomy	_____	☐ Neck	_____	☐ _________	_____

Social History:

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced

You live with:
- ☐ Alone
- ☐ Spouse
- ☐ Children
- ☐ Partner
- ☐ Other: ________

You live at:
- ☐ Your home
- ☐ Relative's home
- ☐ Assisted Living Facility
- ☐ Nursing home
- ☐ Other: _____________

Education completed:
- ☐ Grade school
- ☐ High school/GED
- ☐ Some college
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ PhD and above

Current or most recent occupation:

____

- ☐ Retired – year: ___________
- ☐ Disabled – year: ___________

Do you use alcohol?
- ☐ Never
- ☐ Quit: When? __________
- ☐ Yes: Drinks per week ______

Smoking history:
- ☐ Never smoked
- ☐ Currently smoke _____ packs/day
- ☐ Quit smoking in _____

Lifetime cigarette use:

____ packs/day for ____ years

Please continue on reverse side

Have you ever had: ☐ Blood Transfusion; ☐ Hepatitis: type ☐ A ☐ B ☐ C ☐ HIV (AIDS); ☐ Substance abuse

Family History
For each of the disorders listed below, indicate in the column titled **"Rel"** which family member(s) had the illness, using the abbreviations listed.

Relationship Abbreviations:

M	Mother
F	Father
B	Brother
S	Sister
C	Child
GP	Grandparent
O	Other

Rel.	Disease	Rel.	Disease	Rel.	Disease
	ADD/ADHD		Dystonia		Parkinson's
	Alzheimer's		Heart disease		Stroke
	Cancer		High Blood Pressure		Substance Abuse
	Depression		Muscle Problem		Tremors
	Dementia		Neuropathy		Tics/Tourette
	Diabetes		OCD		

Review of Systems: ***Please indicate if you are CURRENTLY experiencing any of the following conditions:***

Constitutional	Yes	No
Fever	☐	☐
Chills	☐	☐
Weight Loss	☐	☐
Fatigue	☐	☐
Profuse Sweating	☐	☐
Weakness	☐	☐

Eyes	Yes	No
Blurred Vision	☐	☐
Double Vision	☐	☐
Sensitive to Light	☐	☐
Eye Pain	☐	☐
Eye Discharge	☐	☐
Eye Redness	☐	☐

Gastrointestinal	Yes	No
Heartburn	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Stomach Pain	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Blood in stool	☐	☐
Dark Tarry Stools	☐	☐

Endo/Heme	Yes	No
Easy to Bruise	☐	☐
Seasonal Allergies	☐	☐
Excessive Thirst	☐	☐

Neurological	Yes	No
Dizziness	☐	☐
Tingling	☐	☐
Tremors	☐	☐
Change in touch	☐	☐
Speech change	☐	☐
Weakness	☐	☐
Seizures	☐	☐
Loss of Consciousness	☐	☐
Involuntary Mvmts	☐	☐
Poor Concentration	☐	☐
Restless Legs	☐	☐

Skin	Yes	No
Rash	☐	☐
Itching	☐	☐

Cardiovascular	Yes	No
Chest pain	☐	☐
Pounding Heart	☐	☐
Shortness of breath	☐	☐
Leg Swelling	☐	☐

Genitourinary	Yes	No
Painful Urination	☐	☐
Urgency	☐	☐
Frequency	☐	☐
Blood in Urine	☐	☐
Side Pain	☐	☐

Head/ENT	Yes	No
Headaches	☐	☐
Hearing Loss	☐	☐
Ringing in ears	☐	☐
Ear Pain	☐	☐
Ear Discharge	☐	☐
Nose Bleeds	☐	☐
Loss of Smell	☐	☐
Congestion	☐	☐
Wheezing	☐	☐
Sore Throat	☐	☐

Respiratory	Yes	No
Cough	☐	☐
Coughing up Blood	☐	☐
Phlegm Production	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐

Musculoskeletal	Yes	No
Muscle Pain	☐	☐
Neck Pain	☐	☐
Back Pain	☐	☐
Joint Pain	☐	☐
Falls	☐	☐
Cramps	☐	☐

Psychiatric	Yes	No
Depression	☐	☐
Suicidal Ideas	☐	☐
Substance Abuse	☐	☐
Hallucinations	☐	☐
Nervous/Anxious	☐	☐
Sleeping Disorder	☐	☐
Memory Loss	☐	☐

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Medication Questionnaire for New Patients

Have you taken any of these medications? If so, please list the dose and frequency.

If you have stopped taking the medication for any reason, please tell us why

Sinemet (Carbidopa/Levodopa) Strength (mg): ____10/100 ___ 25/100 _____25/250

____ Still Taking _____ Stopped # of doses per day: ______ # of tablets per dose: _____

If stopped, why? ____

Sinemet CR (Carbidopa/Levodopa Controlled Release) Strength (mg): ____25/100 ____ 50/200

____ Still Taking _____ Stopped # of doses per day: ______ # of tablets per dose: _____

If stopped, why? ____

Rytary (Carbidopa/Levodopa Extended Release) Strength (mg): ____23.75/95 ___ 36.25/145 ___ 48.75/195 ___ 61.25/245
IPX066
____ Still Taking _____ Stopped # of doses per day: ______ # of tablets per dose: _____

If stopped, why? ____

Stalevo Strength (mg): _____50mg ____ 100mg _____150mg _____ 200mg

____ Still Taking _____ Stopped # of doses per day: ______ # of tablets per dose: _____

If stopped, why? ____

Eldepryl (selegiline) Strength (mg): ____5mg

____ Still Taking _____ Stopped # of doses per day: ______ # of tablets per dose: _____

If stopped, why? ____

Azilect (rasagiline) Strength (mg): ____0.5mg ____ 1.0mg

____ Still Taking _____ Stopped # of doses per day: ______ # of tablets per dose: _____

If stopped, why? ____

Parcopa Strength (mg): ____ 25/100 _____ 25/250

____ Still Taking _____ Stopped # of doses per day: ______ # of tablets per dose: _____

If stopped, why? ____

Form Continues on Back

Mirapex (pramipexole) Strength (mg): ____0.125mg ____ 0.25mg _____0.5mg _____1.0mg ____1.5mg

____ Still Taking _____ Stopped # of doses per day: ______ # of tablets per dose: _____

If stopped, why? ____

Neupro (rotigotine) Strength (mg): ____2mg ___ 4mg _____6mg _____ 8mg

____ Still Taking _____ Stopped # of doses per day: ______ # of tablets per dose: _____

If stopped, why? ____

Apokyn (apomorphine) Strength (mg): ____10mg/ml

____ Still Taking _____ Stopped # of doses per day: ______ # of tablets per dose: _____

If stopped, why? ____

Requip (ropinirole) Strength (mg): ____0.25mg ___ 0.5mg ____1mg ____2mg ____3mg ____4mg ____5mg

____ Still Taking _____ Stopped # of doses per day: ______ # of tablets per dose: _____

If stopped, why? ____

Artane (trihexyphenidyl) Strength (mg): ____2.0mg ____ 5.0mg

____ Still Taking _____ Stopped # of doses per day: ______ # of tablets per dose: _____

If stopped, why? ____

Comtan (entacapone) Strength (mg): _____ 200mg

____ Still Taking _____ Stopped # of doses per day: ______ # of tablets per dose: _____

If stopped, why? ____

Congentin (benztropine) Strength (mg): ______

____ Still Taking _____ Stopped # of doses per day: ______ # of tablets per dose: _____

If stopped, why? ____

Tasmar (tolcapone) Strength (mg): ____100mg ____ 200mg

____ Still Taking _____ Stopped # of doses per day: ______ # of tablets per dose: _____

If stopped, why? ____

Symmetrel (amantadine) Strength (mg): ____100mg

____ Still Taking _____ Stopped # of doses per day: ______ # of tablets per dose: _____

If stopped, why? ____