RAAM SAMBANDAM, MD
BOARD CERTIFIED NEUROLOGIST

SYNAPSE
NEUROLOGY

Name	_____ SS# _____/_____/_____
Birth Date	_____/_____/_____ Marital Status: ☐ M ☐ D ☐ S ☐ Other _____
Address	Street _____ City _____ State _____ Zip _____
Phone #	Cell _____ Home _____ Work _____ Email address _____
Pharmacy Phone	Name _____ Phone _____ Street _____ City _____ State _____ Zip _____ Cell _____ Home _____ Work _____ Email address _____
Race	☐ White/Caucasian ☐ Black/African ☐ Asian ☐ Hispanic ☐ Native American ☐ Other _____
Ethnicity	☐ Hispanic or Latino ☐ Non-Hispanic or Latino
Occupation	_____ Dominant hand ☐ Right ☐ Left
Insurance Information	Insurance Plan 1 Name _____ Policy # _____ Insurance Plan 2 Name _____ Policy # _____ Policy Holder's Name _____ DOB _____ SS# _____ Workers' Comp: ☐ Yes ☐ No Auto Accident: ☐ Yes ☐ No Date of Injury:_____ Claim # _____ Place of Accident _____
Social History	Are you a current smoker? ☐ Yes ☐ No Past Smoker? ☐ Yes ☐ No If yes, when did you quit? _____ Do you drink alcohol? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never How much do you drink at these times? _____ Was there a time you used alcohol significantly more than now? ☐ Yes ☐ No

Synapse Neurology
2753 Citrus Tower Blvd, Clermont, FL 34711
Phone: 352-404-7712 Fax: 352-404-7713

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CHIEF COMPLAINT FOR YOUR VISIT WITH THE NEUROLOGIST TODAY _____

_____

PRIMARY CARE PHYSICIAN/REFERRING PHYSICIAN _____

NEUROLOGICAL PROBLEMS - Check all that may apply:

	Migraine		Numbness/tingling in arms/hands
	Headache		Numbness/tingling in legs/feet
	Dizziness		Numbness other(specify site)
	Head injury		Tremor/Abnormal movements
	Motor vehicle accident		Walking/balance problems
	New vision problems		Unsteady gait
	Speech problem		Frequent falls
	Jaw pain		Blackout / Fainting
	Facial pain (Left / Right)		Seizures
	Swallowing problem / disorders		Epilepsy
	Neck pain		Memory loss / problems
	Back pain		Dementia
	Arm pain (Left / Right)		Stroke / TIA
	Wrist pain (Left / Right)		Parkinson's disease
	Shoulder pain (Left / Right)		Bell's Palsy
	Knee pain (Left / Right)		Huntington's disease
	Leg Pain (Left / Right)		Trigeminal Neuralgia
	Weakness in arms/hands		Muscular Dystrophy
	Weakness in legs/feet		Multiple Sclerosis

Have you had any tests for your symptoms? (MRI, CT, EMG/NCS, EEG/Labs)

What _____

When _____

Where _____

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PAST MEDICAL HISTORY

PREVIOUS SURGERIES	

MEDICATION ALLERGIES: ☐ Yes ☐ No	
Substance	Reaction

MEDICAL HISTORY

YES	NO	
		High blood pressure
		Diabetes/Pre diabetes
		High cholesterol
		History of cancer
		Heart diseasae

Please list other medical problems:

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FAMILY HISTORY

Is there a family history of neurological disease (stroke, seizures, brain tumor, 'nerve' problems)	
Is there a family history of any other medical problems?	

MEDICATION LIST

Name of medication	How many per day	Dose	Prescribing physician

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REVIEW OF SYSTEMS - PLEASE MARK "YES" IF A CURRENT PROBLEM

YES	NO	
		Weight gain
		Weight loss
		Hearing change
		Blurry vision
		Eye glass use
		Ringing in ear
		Ear bleeds
		Nose bleeds
		Nasal discharge
		Nasal obstruction
		Gum bleeds
		Denture use
		Shortness of breath
		Wheezing
		Coughing up blood
		Chest pain
		Rapid or irregular heart beat
		Heartburn/acid reflux
		Stomach pain
		Bowel habit change
		Nausea/vomiting
		Blood in stool
		Increased urine frequency
		Pain with urination