Perez Neurology
2695 S LeJeune Road
Suite 200
Coral Gables, FL 33134
P: 305-529-5558
F: 305-529-5854
perezneurologymanager@gmail.com
www.perezneurology.com

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Patient Intake Form

Personal Information:
Name: _____
Date of Birth: _____
Gender: [ ] Male [ ] Female
Address: _____
City: _____ State: _____ ZIP: _____
Primary Phone: _____ Email: _____

[ ] I agree to receive text and/or email reminders about my upcoming scheduled appointments.

Emergency Contact:
Name: _____
Relationship to Patient: _____
Phone: _____

Primary Care Physician:
Name: _____
Phone: _____
Fax:_____

Preferred Pharmacy:
Name: _____
Address:_____
Zip Code: _____
Phone Number: _____

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Insurance Information:

Primary Insurance: _____
Policy/ID Number: _____
Group Number: _____
Insurance Phone: _____

Secondary Insurance (if applicable):
Policy/ID Number: _____
Group Number: _____
Insurance Phone: _____

Payment Information:

Credit Card on File:
Name on Card: _____
Card Number: _____
Security Code: _____
Expiration Date: _____

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Medical History:
Please check any medical conditions you have or have had in the past:
[ ] Hypertension
[ ] Diabetes
[ ] Heart Disease
[ ] High Cholesterol
[ ] Thyroid Disorders
[ ] Respiratory Disorders (e.g., Asthma, COPD)
[ ] Gastrointestinal Disorders (e.g., GERD, IBS)
[ ] Kidney Disease
[ ] Liver Disease
[ ] Autoimmune Disorders (e.g., Rheumatoid Arthritis, Lupus)
[ ] Cancer (please specify type): _____
[ ] Mental Health Disorders (e.g., Depression, Anxiety)
[ ] Other (please specify): _____

Neurological History:
[ ] Epilepsy
[ ] Stroke
[ ] Multiple Sclerosis
[ ] Parkinson's Disease
[ ] Alzheimer's Disease
[ ] Headaches/Migraines
[ ] Neuropathy
[ ] Sleep Disorders
[ ] Head trauma
[ ] Other (please specify): _____

Infectious History:
[ ] Tick-borne illness
[ ] West Nile Virus
[ ] Other: _____

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Have you ever had vaccine-related neurological illness i.e., Guillain Barre? Y [ ] N [ ]

Please list any surgeries you have had and their dates:
1. _____
2. _____
3. _____

Please list any implantable medical devices (i.e. Pacemaker, AICD, IUD, Nexplanon):
1._____
2._____
3._____

Current Medications (Include birth control, over-the-counter medications, and vitamins/ supplements):
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Allergies (Include medications, foods, and environmental allergies):
1. _____
2. _____
3. _____

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Family History:
Please indicate if any of your family members (parents, siblings, children) have had the following conditions:
[ ] Hypertension
[ ] Diabetes
[ ] Heart Disease
[ ] High Cholesterol
[ ] Thyroid Disorders
[ ] Respiratory Disorders (e.g., Asthma, COPD)
[ ] Gastrointestinal Disorders (e.g., GERD, IBS)
[ ] Kidney Disease
[ ] Liver Disease
[ ] Autoimmune Disorders (e.g., Rheumatoid Arthritis, Lupus)
[ ] Cancer (please specify type): _____
[ ] Mental Health Disorders (e.g., Depression, Anxiety)
[ ] Other (please specify): _____

Neurological History:
[ ] Epilepsy
[ ] Stroke
[ ] Multiple Sclerosis
[ ] Parkinson's Disease
[ ] Alzheimer's Disease
[ ] Headaches/Migraines
[ ] Neuropathy
[ ] Sleep Disorders
[ ] Other (please specify): _____

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Social History:
Do you smoke? [ ] Yes [ ] No
If yes, how much per day? _____

Do you drink alcohol? [ ] Yes [ ] No
If yes, how much per week? _____

Do you use recreational drugs? [ ] Yes [ ] No
If yes, please specify: _____

Approximate number of hours of sleep per night _____
Comments regarding sleep _____

Dietary Habits
Please select all that apply:
[ ] Ketogenic diet
[ ] Diabetic diet
[ ] Intermittent fasting
[ ] Whole foods diet
[ ] Vegetarian/Vegan
[ ] Other: _____

Exercise/ Activity
[ ] Frequent exercise and activity, 3 or more times per week
[ ] Moderate amount of activity, 1-2 times per week
[ ] Little to no exercise/ activity
[ ] Other: _____

Psychological
[ ] I have a support system and/or caregiver
[ ] I do not have a support system and/or caregiver
[ ] I socialize often
[ ] I do not socialize often

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[ ] I have had a recent traumatic or stressful event in my life

Please provide any additional information you think is relevant to your neurological care:

Signature: _____
Date: _____

Thank you for completing this form. If you have any questions or concerns, please feel free to discuss them with our staff.

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