



Juan Muniz, M.D.

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Interventional Neurology

Ali R. Malek, MD, FSNIS
Vascular Neurology-Neurocritical Care
Neurology Endovascular Neurosurgery

Nils Mueller-Kronast, MD
Vascular Neurology-Neurocritical Care
Neurology

Neurology

Paul Acevedo, MD
Adult Neurology

Jennifer Buczyner, MD
Neurology-Neurophysiology-
Neuromuscular Disorders

Arif Dalvi, MD, MBA
Neurology Parkinson's Disease
Movement Disorder

Pedro Hernández-Frau, MD
Neurology-Neurophysiology-Epilepsy

Juan Carlos Muniz, MD
Neurology-Neurophysiology-Epilepsy

Paayal Patel, MD
Neurology-Cognitive Behavioral
Neurology-Neuropsychiatry

Arun Venugopal Talkad, MD
Neurology-Vascular Neurology

Internal Medicine

Martha L. Zambrano, MD
Internal Medicine

Neuropsychology

Nicholas DePrima, PsyD
Neuropsychology-Rehabilitation
Psychology

Courtney Spilker, PsyD
Neuropsychology

What is a Neurologist?

A neurologist is a physician who diagnose and treats disorders of the nervous system. This includes diseases of the brain, spinal cord, nerves and muscles. Neurologist may serve as a consultant to other physicians, as well as providing long-term care to patients with chronic neurological disorders.

A neurologist is **NOT** the same as a pain management specialist. We will evaluate you, diagnose your condition and propose the most appropriate therapeutic regimen. In cases of chronic pain, we may refer you to a pain management specialist for further evaluation and treatment. The neurologists of this practice **DO NOT** prescribe narcotics.

Please note, under no circumstances will we automatically renew your existing or prior pain medication prescription.

Our goal is to provide you with the best neurological care possible today. We highly value the doctor-patient relationship and feel that mutual respect is necessary at all times.

We appreciate your understanding of our practice policy. Please take a moment to acknowledge this with your signature below. Thank you.

Patient or Guardian Signature

Date

Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____

Medication List (Current Medications)

Medication Name	Dose	Times per day

Allergies

Allergic to any medications: Yes No

If yes please list name of medication (s):

Review of Systems

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Stroke	<input type="checkbox"/> Tremor/shakes
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> TIA	<input type="checkbox"/> Muscle Stiffness
<input type="checkbox"/> Shortness of breathe	<input type="checkbox"/> Visual Disturbance	<input type="checkbox"/> Slow movements
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Depression	<input type="checkbox"/> Change in posture
<input type="checkbox"/> Cancer	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Poor balance
<input type="checkbox"/> Liver disease	<input type="checkbox"/> Memory disorder	<input type="checkbox"/> Falls
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Skin rashes	<input type="checkbox"/> Difficulty with sleep
<input type="checkbox"/> Anemia	<input type="checkbox"/> Drooling	<input type="checkbox"/> Bladder frequency

History & Physical

Dr. Juan Muniz, M.D.

Medical History (If you are uncertain of the exact date, write year)

Disease

Allergies	_____	Heart Attack	_____
Anemia	_____	Hepatitis	_____
Angina	_____	High Cholesterol	_____
Arthritis	_____	Hypertension	_____
Asthma	_____	Hyperthyroid	_____
Benign Prostate Hypertrophy	_____	Hypothyroid	_____
Cancer (Type)	_____	Migraine/Headaches	_____
_____	_____	Rheumatic Fever	_____
Cirrhosis	_____	Seizures	_____
Diabetes	_____	Stoke	_____
Diverticular Disease	_____	Tuberculosis	_____
Eczema	_____	Other	_____
Emphysema	_____	_____	_____

Surgical History

Procedure	Year	Surgeon's Name

Family History

	Medical Problem	Age	Living or Deceased	Cause of Death
Mother				
Father				
Sibling				
Other				

Social History

Smoke: No Yes Frequency _____

Alcohol: No Yes Frequency _____

Caffeine: No Yes Frequency _____

Drugs: No Yes Frequency _____

Hand Dominance: Right Left Ambidextrous

I certify that the above information is correct to the best of my knowledge:

Patient signature: _____ Date: _____