TRIGEMINAL NEURALGIA QUESTIONNAIRE

Name:________________________________________________________________________

Date of birth:___________________________  E-mail address: ___________________________

Address:________________________________________________________________________
                                                                                       
                                                                                       
Contact phone #’s: (H)____________________ (W)___________________ (C)________________

Medical Insurance: Name of Carrier___________________________________________________

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Primary Care Physician Information: Name______________________________________________

Primary Care Physician Information: Name______________________________________________

Primary Care Physician Information: Name______________________________________________

Which side of your face is painful? _______________________________________________________

Please describe the pain (sharp, dull, electrical, constant, intermittent, shooting, etc.)

How long have you been experiencing pain? _______________________________________________

What triggers the pain? __________________________________________________________________

What relieves the pain to make it better (medication, activity, treatment)? ______________________

Do you have a history of cold sores, fever blisters, shingles or chickenpox? _______ When did this

happen and where were the lesions?_______________________________________________________

_____________________________________________________________________________________

Have you ever had any procedures or surgeries for your trigeminal neuralgia?

Have you ever been evaluated by a neurologist (please provide details):___________________________

_____________________________________________________________________________________
Have you ever had a brain MRI scan for your neuralgia? ____________  When? ___________________________

Do you have a pacemaker or a history of heart surgery? __________  _______________________________

What kind of pacemaker or surgery and when? ________________________________________________

Are you currently taking any aspirin, anti-inflammatory medications (Aleve, Motrin, Ibuprofen) or anti-platelet medication (Plavix, Agranox, etc)? ________________________________________________

Who manages this medication (primary physician/neurologist/ cardiologist – please provide name and number)? ________________________________________________________________________________

Are you interested in surgical intervention?  ___________________________________________________________________________________

**Review of Systems:**  Height: ______________  Weight ______________

Please circle and provide any information on the medical conditions below which apply to you in the past or present:

**Constitutional:**
- Weight loss or gain
- Change in appetite
- Altered taste or smell
- Inability to sleep
- Fatigue
- Fever

**Cardiovascular:**
- Chest pain/pressure
- Angina
- Leg swelling
- High blood pressure
- Low blood pressure
- Shortness of breath

**Dermatological:**
- Fainting
- Skin rash
- Skin lesions

**Genitourinary:**
- Painful urination
- Frequent urination
- Urinary urgency
- Urinary incontinence

**Eye:**
- Glaucoma
- Cataracts
- Blurred vision
- Double vision

**Eyes:**
- Contact lenses

**Ear, Nose, Mouth, Throat:**
- Hearing loss
- Ringing in ears
- Dizziness
- Nose bleeds/discharge
<table>
<thead>
<tr>
<th>Medical Conditions</th>
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<tbody>
<tr>
<td>Trouble breathing through nose</td>
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<td>Sinus disease</td>
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<td>Mouth sores</td>
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<td>Sore throat or difficulty swallowing</td>
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<td><strong>Heme/Lymphatic:</strong></td>
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<td>Blood disorder</td>
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<td>Enlarged lymph nodes</td>
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<tr>
<td>Blood transfusions</td>
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<tr>
<td><strong>Psychological:</strong></td>
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<td>Difficulty concentrating</td>
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<td><strong>Musculoskeletal:</strong></td>
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<td>Low back pain</td>
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<tr>
<td>Neck pain</td>
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<tr>
<td>Joint pain</td>
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<tr>
<td>Joint swelling</td>
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<tr>
<td><strong>Respiratory:</strong></td>
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<td>Emphysema</td>
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<td>Chronic Cough</td>
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<tr>
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<tr>
<td>Diarrhea</td>
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<td>Diabetes</td>
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<td>Thyroid Disease</td>
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<tr>
<td>Breast disease</td>
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<tr>
<td><strong>Neurological:</strong></td>
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<tr>
<td>Headache</td>
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<tr>
<td>Seizure</td>
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<td>Loss of consciousness</td>
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<td>Memory loss/vertigo</td>
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<td>Weakness/numbness</td>
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<td>Tingling/falls</td>
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<td>Concussion</td>
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<td>Trouble walking</td>
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<tr>
<td>Difficulty with balance</td>
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<tr>
<td>Brain tumor</td>
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<tr>
<td>Brain aneurysm</td>
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<tr>
<td>Hydrocephalus</td>
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<tr>
<td>Multiple sclerosis</td>
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<tr>
<td>Lyme’s disease</td>
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</tbody>
</table>

**Past Medical History:**

Please indicate all operations you have had in the past for any reason with approximate dates:

1. ____________________________ 5. ____________________________
2. ____________________________ 6. ____________________________
3. ____________________________ 7. ____________________________
4. ____________________________ 8. ____________________________

Have you ever had a problem with Anesthesia? If so, when and what kind of problem? _______

______________________________________________________________________________
Please list ALL other current medical problems/major illnesses you have had in the past with dates:
1. ____________________________________________  5. ____________________________________________
2. ____________________________________________  6. ____________________________________________
3. ____________________________________________  7. ____________________________________________
4. ____________________________________________  8. ____________________________________________

Please list ALL **medications** you are currently taking with dosage (include over the counter drugs such as vitamins, supplements, herbal supplements, etc)
1. ____________________________________________  5. ____________________________________________
2. ____________________________________________  6. ____________________________________________
3. ____________________________________________  7. ____________________________________________
4. ____________________________________________  8. ____________________________________________

**Allergies:** Please list all medications or foods (with reactions please)
1. ____________________________________________  5. ____________________________________________
2. ____________________________________________  6. ____________________________________________
3. ____________________________________________  7. ____________________________________________
4. ____________________________________________  8. ____________________________________________

(Women ONLY)

Last menstrual period: ____________________________________________

# Pregnancies:__________________________  # Deliveries:_____________________

**Family History:**

Please list any major medical problems in grandparents, parents, brothers, sisters and children (in whom & at what age).
1. ____________________________________________  5. ____________________________________________
Social History:

Please list your highest level of education:________________________________________________
Where are you employed and what is your position (if retired, please give date of retirement):______
___________________________________________________________________________________
Please indicate your marital status:_______________________________________________________
Spouse’s occupation:__________________________________________________________________
Current living arrangements:____________________________________________________________
Do you smoke?_____ If you do smoke, how many packs per day?_____ If you quit, when?__________
Do you drink alcohol?_____ What kind of alcohol and how many drinks per week?_________________
If you drank and quit, when did you quit?_______________________________________________
Have you ever had a problem with alcohol or drugs?______
If you have had difficulty, what was the substance and when?_____________________________________

Thank you for taking the time to fill out this form. It will assist us in giving you the best care possible.

PLEASE RETURN ALONG WITH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD(S).

PLEASE FAX TO: 410-630-7865

Or email to: NUSaccess@jhmi.edu

Thank you!