OUTPATIENT NEUROLOGY SERVICE
NEW PATIENT QUESTIONNAIRE
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Neurology Clinic Physicians

What is your current age? _____ Are you ___ Right-handed or ___ Left-handed or ___ Both?

<table>
<thead>
<tr>
<th>YOUR NAME AND ADDRESS</th>
<th>CONTACT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>____________________________________________________________________</td>
<td>Daytime Phone: __________________________</td>
</tr>
<tr>
<td>____________________________________________________________________</td>
<td>Home Phone: ______________________________</td>
</tr>
<tr>
<td>____________________________________________________________________</td>
<td>Email: ___________________________________</td>
</tr>
<tr>
<td>____________________________________________________________________</td>
<td>Fax: _____________________________________</td>
</tr>
</tbody>
</table>

Who referred you for this evaluation? Physician’s Name: ____________________________

Address: ____________________________________________________________________

City: ____________________________ State: ____________________________ Zip: __________

Phone No: ____________________________ Fax No: ____________________________

What do you see as your main problem or concern?
(Describe when and in what circumstances it started, what part of the body it affects, if it is still worsening, if anything makes it better or worse, if it is worse at a particular time of day, how long does it last if it is intermittent, how it has affected you and what medicines/surgery if any, you have already tried for it)
**MEDICAL HISTORY:**

The following is a list of possible medical illnesses. **Please place an “X” beside any that you have or have had in the past.** Please leave the area labeled “Notes” blank for the physician’s use.

<table>
<thead>
<tr>
<th>Illness</th>
<th>Notes (please don’t write in this column)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td></td>
</tr>
<tr>
<td>Seizures or Epilepsy</td>
<td></td>
</tr>
<tr>
<td>Peripheral Neuropathy</td>
<td></td>
</tr>
<tr>
<td>Head Injury</td>
<td></td>
</tr>
<tr>
<td>Hypertension (high blood pressure)</td>
<td></td>
</tr>
<tr>
<td>Heart attack or coronary artery disease</td>
<td></td>
</tr>
<tr>
<td>Heart Failure</td>
<td></td>
</tr>
<tr>
<td>Irregular heart beat or Arrhythmia</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>High cholesterol</td>
<td></td>
</tr>
<tr>
<td>Asthma or COPD or Emphysema</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
</tr>
<tr>
<td>Thyroid disease</td>
<td></td>
</tr>
<tr>
<td>Arthritis – osteoarthritis / Rheumatoid arthritis</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
</tr>
</tbody>
</table>

Other: __________________________
### SURGICAL HISTORY:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Year</th>
<th>Procedure</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tonsillectomy (tonsils removed)</td>
<td></td>
<td>Adenoidectomy (adenoids removed)</td>
<td></td>
</tr>
<tr>
<td>Appendectomy (appendix removed)</td>
<td></td>
<td>Hysterectomy (uterus removed)</td>
<td></td>
</tr>
<tr>
<td>Cholecystectomy (gallbladder removed)</td>
<td></td>
<td>Coronary Artery Bypass Graft / Stent</td>
<td></td>
</tr>
</tbody>
</table>

Please list any other surgery that you have had, including the year:

<table>
<thead>
<tr>
<th>Year</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### OBSTETRIC & GYNECOLOGIC HISTORY: (For women only)

<table>
<thead>
<tr>
<th>Last menstrual period:</th>
<th>Last Gynecologic exam:</th>
<th>Last PAP smear:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Pregnancies: **Miscarriages:**

<table>
<thead>
<tr>
<th>Last Mammogram:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### ALLERGIES:

Please list all drugs that you are allergic to and **describe** what the allergic reaction was:

### REVIEW OF SYSTEMS:

**GASTROINTESTINAL**
- Loss of appetite
- Diarrhea
- Constipation
- Blood in stools
- Rectal bleeding

**EYES**
- Blurred vision
- Double vision
- Eye injury
- Discharge from eyes

**EAR / NOSE / THROAT**
- Hearing loss
- Ringing in ears
- Dizziness
- Vertigo
- Discharge from ears or nose
- Nose bleeds
- Bleeding gums
- Sinusitis
- Lack of taste or smell

**INTEGUMENTARY**
- Skin rash
- Itching
- Change in skin color
- Change in hair or nails
- Breast pain
- Breast lump
- Breast discharge

**CONSTITUTIONAL SYMPTOMS**
- Fever
- Night sweats
- Fatigue
- Weight gain
- Weight loss

**RESPIRATORY**
- Chronic cough
- Coughing up blood
- Wheezing
- Shortness of breath

**CARDIOVASCULAR**
- Chest pain
- Irregular heart beat
- Shortness of breath
- Palpitations
- Swelling (feet, ankles, hands)

**GENITOURINARY**
- Urinary urgency
- Frequent urination
- Blood in urine
- Painful urination
- Incontinence
- Vaginal discharge

**INTEGUMENTARY**
- Skin rash
- Itching
- Change in skin color
- Change in hair or nails
- Breast pain
- Breast lump
- Breast discharge
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REVIEW OF SYSTEMS
(continued):

MUSCULOSKELETAL
Join Pain
Joint Stiffness
Joint Swelling
Back Pain
Neck Pain
Cold extremities

ENDOCRINE
Heat or cold intolerance
Excessive thirst or urination
Change in hat or glove size

HEMATOLOGIC/LYMPHATIC
Enlarged nodes or glands
Bleeding tendency
Anemia
Phlebitis

PSYCHIATRIC
Anxiety
Low mood
Fear
Panic attacks
Sadness
Visual hallucinations
Auditory hallucinations

NEUROLOGIC
Headache
Weakness
Stiffness
Numbness
Seizures or convulsions
Tingling
Difficulty chewing
Choking
Difficulty walking
Falls
Tremors
Memory loss
Confusion
Trouble concentrating
Insomnia / trouble sleeping
Snoring

SOCIAL HISTORY:

__ Single       __ Married       __ Divorced       __ Widowed       __ Separated       __ Partnered
Highest Level of Education Completed: __ 6th Grade   __ 12th Grade   __ G.E.D.   __ College   __ Post-Graduate
Your employment/occupation ___________________________________ How long? _____________________
Previous Occupations: _______________________________________________________________________

HABITS: (so we may determine the best way to care for you)

<table>
<thead>
<tr>
<th></th>
<th>Present</th>
<th>Past</th>
<th>Age at start</th>
<th>Amount</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco (smoking, chewing)</td>
<td>Yes/No</td>
<td>Yes/No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>Yes/No</td>
<td>Yes/No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Substances</td>
<td>Yes/No</td>
<td>Yes/No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(marijuana, cocaine, heroin, etc)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caffeinated Foods</td>
<td>Yes/No</td>
<td>Yes/No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(tea, coffee, chocolate)</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

All other systems reviewed and are negative.

NOTES
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NEW PATIENT QUESTIONNAIRE
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Has the problem you are currently having caused:
Job-Related Problems? __ Yes __ No
School Problems? __ Yes __ No
Legal Problems? __ Yes __ No
Driving Problems? __ Yes __ No

FAMILY HISTORY:

<table>
<thead>
<tr>
<th>Relative</th>
<th>Current Age(s)</th>
<th>Major Illness(es) (Past or Present?)</th>
<th>If Deceased, Cause of Death?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sister(s)/Brother(s): please list</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

THIS FORM IS CONFIDENTIAL AND PART OF YOUR MEDICAL RECORD. THANK YOU!

NAME OF PERSON COMPLETING THIS FORM: ______________________________________

REVIEWED BY:

_________________________________________ M.D.  _____________________________ M.D.  DATE: ____________

SIGNATURE PRINTED