

NEUROLOGICAL MEDICINE

NAME _____

NEW PATIENT QUESTIONNAIRE

DATE _____

PRIMARY PHYSICIAN'S NAME AND ADDRESS

OTHER PHYSICIAN'S NAME AND ADDRESS

Age: _____ Are you Right-handed or _____ Left-handed? _____

Race: _____

Describe your headache problem:

Age your headaches began: _____

How often do your headaches occur? _____

What does it feel like? _____

How severe is your pain? Mild _____ Moderate _____ Severe _____

What parts of your head and neck hurt? _____

Do you lie down with your headaches? _____

With your headaches, do you have: (circle all that apply)

Nausea
Vomiting

light-sensitivity
sound-sensitivity

vision changes
numbness or tingling

For women, are your headaches associated with your menstrual periods? _____

Does anything trigger you headaches? _____

Have you had a brain CT or MRI? _____

Have you seen a neurologist for your headaches? _____

List treatments you have tried: _____

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MEDICAL ILLNESS: Check all that you have at the present:

- | | | |
|----------------|----------------|-------------------|
| Hypertension | Arthritis | Kidney Failure |
| Angina | Lupus | Prostate Disease |
| Heart Attack | Muscle Disease | Bladder Disease |
| Arrhythmia | Depression | Seizures/Epilepsy |
| Blood Clots | Anxiety | Stroke |
| Asthma | Panic Attacks | Back Problems |
| Stomach Ulcers | Anemia | Thyroid Disease |
| Hepatitis | Cancer | High Cholesterol |
| Kidney Stones | Diabetes | Broken Bones |
| | | Trauma(Accidents) |

Other: _____

SURGICAL HISTORY: Check all that apply:

- | | | |
|---------------|------------------|-------------------------|
| Tonsillectomy | Appendectomy | Coronary Artery Surgery |
| Hysterectomy | Ovaries Removed | Heart Valve Surgery |
| | Cataract Removed | Carotid Artery Surgery |

Other: _____

SYSTEMS REVIEW: check all that you have had in the past 6 weeks

- | | | |
|---|----------------|--------------------------------|
| Weight Loss/Gain | Diarrhea | Impotence |
| Rash | Constipation | Sexual Problems |
| Fever | Vomiting | Trouble Sleeping |
| Chest Pain | Blood in Stool | Last Menstrual Period _____ |
| Shortness of Breath | Blood in Urine | # of Pregnancies _____ |
| Cough | | # Abortions/Miscarriages _____ |
| Hormone Therapy—Birth Control Pills _____ | | |
| Hormone Replacement Therapy _____ | | |

SOCIAL HISTORY:

- Single ___ Married ___ Widowed ___ Partnered ___
- With whom do you live? _____
- Education Completed: _____
- Employment/occupation _____
- Has the problem you are currently having caused problems?: Job ___ School ___ Legal ___
- Tobacco? Yes ___ No ___
- How many packs per day? _____
- If No, did you ever Smoke _____
- Alcohol? Yes ___ No ___
- Caffeinated Beverages or Foods? Yes ___ No ___
- If Yes, how many servings per day? Coffee ___ Tea ___ Soda Pop ___ Chocolate ___

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FAMILY HISTORY:

Ages Major Illness(es) If Deceased, Cause of death

Mother _____

Father _____

Sister(s): _____

Brother(s): _____

Spouse/Partner _____

Children: _____

Anything we didn't ask that you think we should know about you?
