NEUROLOGICAL MEDICINE

NAME_____
DATE _____

NEW PATIENT QUESTIONNAIRE

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	light-sensitivity	vision changes
Vomiting	sound-sensitivity	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	Overies 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?