

**NEUROLOGY
QUESTIONNAIRE**

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Date: _____

Please complete the following questionnaire as thoroughly as possible.

Name: _____ Age: _____

Referring Doctor: _____ Height: _____

Occupation: _____ Weight: _____

What are your normal work hours? _____

Gender: ___ Male ___ Female

Right Handed? ___ Left Handed? ___ Both? ___

MEDICATIONS:

List all medications you are taking at the present time, both prescription and over the counter:

<u>Name and strength</u>	<u>Frequency</u>	<u>Reason for medication</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies to Medications and reaction: _____

Reason for visit today:

Reviewed by: _____

Revised 04/2007

Significant **PAST** Medical History: Serious illness and/or operations and approximate dates.

Please Check:

Allergies	Diabetes	Knee Replacement
Appendectomy	Emphysema	Mastectomy
Arthritis	Fibromyalgia	Multiple Sclerosis
Asthma	Gallbladder Surgery	Parkinson's
Back Pain	Glaucoma	Pneumonia
Biopsy (site)	Head Injury	Prostate Surgery
Brain Surgery	Headache	Seizures
Cancer	Heart Disease	Sleep Apnea
Cataracts	Heart Surgery	Spinal Surgery
Chronic Pain	Hernia Repair	Stroke
Chronic Bronchitis	Hip Replacement	TIA's
Cosmetic Surgery	Hypertension	Tonsillectomy
C-Section	Hysterectomy	Tremor
Depression	Joint Repair	Ulcers

Other: _____

FAMILY HISTORY:

Children: Number _____ Ages _____ Health _____
Mother: Living ___ Yes ___ No ___ Age: _____ Health _____
Father: Living ___ Yes ___ No ___ Age: _____ Health _____
Brothers: Number _____ Ages _____ Health _____
Sisters: Number _____ Ages _____ Health _____

SOCIAL HISTORY:

Marital status: Single ___ Married ___ Widowed ___ Domestic Partner ___

Have you ever smoked? ___ Yes ___ No
If yes, for how many years? _____
Average number of packs per day _____
Have you quit smoking? ___ Yes ___ No
If yes, how long ago? _____
Do you drink caffeinated beverages? ___ Yes ___ No
If yes, how much per day? _____
Do you drink alcoholic beverages? ___ Yes ___ No
If yes, how often? _____
Do you get regular exercise? ___ Yes ___ No
If yes, how often? _____

Do you now or have you had any problems **WITHIN THE PAST YEAR** related to the following systems: Circle Yes or No

Constitutional Symptoms

Weight changes Y N
 Poor appetite Y N
 Change in sleeping habits Y N
 Fatigue Y N
 Other _____

Eyes

Loss of vision Y N
 Double vision Y N
 Blurring of vision Y N
 Other _____

Allergic/Immunologic

Seasonal allergies Y N
 Medication allergies Y N
 Other _____

Neurological

Seizures Y N
 Headaches Y N
 Loss of balance Y N
 Weakness Y N
 Loss of consciousness Y N
 Poor coordination Y N
 Numbness Y N
 Head injury Y N
 Loss of memory Y N
 Speech problems Y N
 Other _____

Endocrine

Too hot/cold Y N
 Tired/sluggish Y N
 Night sweats Y N
 Other _____

Gastrointestinal

Nausea/vomiting Y N
 Indigestion/heartburn Y N
 Difficulty swallowing Y N
 Other _____

Integumentary

Skin rash Y N
 Skin changes Y N
 Other _____

Psychologic

Anxiety Y N
 Depression Y N
 Concentration/focus problems Y N
 Other _____

Musculoskeletal

Bone/joint pain Y N
 Joint stiffness/swelling Y N
 Muscle tenderness Y N
 Back pains Y N
 Other _____

Cardiovascular

Palpitations Y N
 Chest pain Y N
 Sleeping upright to sleep Y N
 Swelling in feet or ankles Y N
 High blood pressure Y N
 Fainting Y N
 Other _____

Ears/Nose/Throat/Mouth

Ringing in the ears Y N
 Congestion Y N
 Enlarged tonsils Y N
 Hearing difficulty Y N
 Other _____

Genitourinary

Frequent urination at night Y N
 Urinary frequency Y N
 Impotence Y N
 Prostate problems Y N
 Other _____

Respiratory

Wheezing Y N
 Coughing Y N
 Shortness of breath Y N
 Other _____

Hematologic/Lymphatic

Swollen glands Y N
 Blood clotting problems Y N
 Anemia Y N
 Easy bruising Y N
 Other _____

Sleep

Snoring Y N
 Pauses in breathing while asleep Y N
 Restless sleep Y N
 Insomnia Y N
 Other _____