Neurology
& Sleep Clinics
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"Where our patients always come first"

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NEUROLOGY NEW PATIENT QUESTIONNAIRE

PATIENTS: PLEASE COMPLETE THIS QUESTIONNAIRE BEFORE YOU SEE THE PHYSICIAN.
The information your answers provide is essential for a thorough evaluation. The following pages include questions regarding your medical history, social history, and family. Please check the boxes or print your response in the given space, as appropriate. If you do not know the answer to a given question, or if it is not applicable in your case, leave it blank. This information will be used to help the physician to learn about you and your medical history in order to make a diagnosis, decide about the specific treatment and plan your general care. This information will be kept strictly confidential. Thank you.

Name: _____ Appointment Date: _____
Primary Ins: _____ ID# _____ Grp# _____
Secondary Ins: _____ ID# _____ Grp# _____
L or R Handed (circle) DOB: _____ Sex: _____ Height: _____Weight: _____
Who referred you for this evaluation? Physician's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Who is your primary care provider (PCP)? _____

What do you see as your <u>main</u> problem or concern?
(Describe when and in what circumstances is started, what part of body it affects, if it still worsening, if anything makes it better or worse, if it is worse at a particular day, how long does it last if it is intermittent, how it has affected you and what medicine/surgery, if any, you have tried)

Previous Tests Related to Today's Visit	Date of Test	Where Was Test Performed?
Most Recent Lab		
MRI Scan of Head/Neck/Back		
CAT Scan of Head/Neck/Back		
Neuropsychological Test		
EMG/NCV		
EEG		
Sleep Study		
Other		
Other		

CURRENT Medications	Dosage	Frequency

Allergy	Reaction	Allergy	Reaction

Medical History

(Please check all that apply)

□ Headaches □ Atrial fibrillation □ Bowel Problems □ Migraines □ Ventricular Arrhythmia
□ Hepatitis □ Stroke □ Aortic Aneurysm □ Ulcerative Colitis □ TIA
□ Abnormal Heart Valve □ Crohn's Disease □ Carotid Stenosis □ Tuberculosis
□ Bladder Problems □ Head Injury □ Emphysema □ Arthritis □ Gout
□ Loss of consciousness – date: _____ □ Seizure – date: _____
□ COPD □ Asthma □ Thyroid disease – hypo □ Thyroid disease – Hyper
□ Depression □ High Cholesterol □ Anxiety □ Diabetes Type I □ Diabetes Type II
□ Osteoporosis □ Glaucoma □ Parkinson's Disease □ Easy Bleeding □ Major Trauma
□ Brain Aneurysm □ Bleeding Disorder □ Cancer – Type: _____
□ Peripheral Neuropathy □ Blood Clots – Lung □ Blood Clots – Leg □ Alcohol Addiction
□ Restless Leg Syndrome (RLS) □ Drug Addiction □ Fibromyalgia □ Stomach Ulcers
□ HIV □ High Blood Pressure □ Prolonged Prednisone Use □ AIDS
□ Heart Attack □ Kidney Problems □ Angina □ Liver Problems
□ Others _____ □ Others _____ □ Others _____

Surgical History

(Please check and list date of surgery for all that apply)

□ Brain Surgery	□ Bowel Surgery	□ Implants Type: _____
□ Neck Surgery	□ Bypass in the legs	□ Intrathecal Pump
□ Back Surgery	□ Gallbladder Surgery	□ Pacemaker Surgery
□ Aneurysm Surgery	□ Gastric bypass surgery	□ Stimulator
□ Carotid Surgery	□ Gynecologic surgery	□ Tonsillectomy
□ Abdominal Surgery	□ Heart surgery	□ Other _____
□ Appendectomy	□ Hysterectomy	□ Other _____

Social History

Please circle or fill in the blank)

Marital Status: Single Married Widowed Divorced Significant Other

Number of children: _____ Ages of children: _____

Highest education completed: Grade school High school College Post-Graduate

Are you employed? Yes No Occupation: _____

Do you have work restrictions? Yes No Last day of work: _____

Personal Habits

Do you:	Yes/No	How Long	How Much	Date Quit
Drink alcohol				
Use caffeine				
Smoke tobacco				
Use smokeless tobacco				
Street Drug: _____				
Street Drug: _____				

Family History: Has any member of you family (not to include spouse or in-laws) ever had the following conditions? If yes, indicate family member.

	Family Member		Family Member
□ Yes □ No Anxiety	_____		
□ Yes □ No Dementia	_____	□ Yes □ No Polyneuropathy	_____
□ Yes □ No Depression	_____	□ Yes □ No Parkinson's Disease	_____
□ Yes □ No Epilepsy	_____	□ Yes □ No Restless Leg Syndrome	_____
□ Yes □ No Migraine Headaches	_____	□ Yes □ No Stoke or TIA	_____
□ Yes □ No Obstructive Sleep Apnea	_____	□ Yes □ No Tremor	_____

Other Conditions: _____

The Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How Sleepy Are You?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- No chance of dozing = 0
- Slight chance of dozing = 1
- Moderate chance of dozing = 2
- High chance of dozing = 3

Write down the number corresponding to your choice in the right hand column. Total your score below

Situation	Chance of Dozing
Sitting and reading	□
Watching TV	□
Sitting inactive in a public place (e.g. a theater or a meeting)	□
As a passenger in a car for an hour without a break	□
Lying down to rest in the afternoon when circumstances permit	□
Sitting and taking to someone	□
Sitting quietly after a lunch without alcohol	□
In a car, while stopped for a few minutes in traffic	□

Total Score _____

Analyze Your Score

Interpretation:

0 – 7: It is unlikely that you are abnormally sleepy.4

8 – 9: You have an average amount of daytime sleepiness.

10 – 15: You may be excessively sleepy depending on situation. You may want to consider seeking medical attention.

16 – 24: You are excessively sleepy and should consider seeking medical attention

Reference: Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. Sleep 1991: 14(6):540-5.

REVIEW OF SYSTEMS:

(Please check all that you have experienced in the last 6 months)

Neurological

- □ Difficulty of walking
- □ Falls
- □ Poor memory
- □ Difficulty finding words
- □ Change in your thinking
- □ Numbness or tingling of face
- □ Numbness or tingling of arm – left side
- □ Numbness or tingling of arm – right side
- □ Numbness or tingling of leg – left side
- □ Numbness or tingling of leg – right side
- □ Seizures
- □ Tremor

Psychiatric

- □ Anger
- □ Excessive worry
- □ Frequent sadness or unhappiness
- □ Panic
- □ Problems with concentration
- □ Unusually high energy or excitability

Gastrointestinal / Genitourinary

- □ Difficulty chewing
- □ Difficulty swallowing
- □ Poor appetite
- □ Constipation
- □ Diarrhea
- □ Nausea
- □ Vomiting
- □ Abdominal pain
- □ Blood in stool
- □ Dark or tarry stool
- □ Incontinence of stool
- □ Incontinence of urine
- □ Urinary frequency
- □ Blood in urine
- □ Pain during sex

Ears/Nose/Throat

- □ Hearing loss – left side
- □ Hearing loss – right side
- □ Ringing in ears
- □ Dizziness
- □ Frequent sore throat
- □ Hoarseness
- □ Snoring
- □ Discharge from nose
- □ Repeated sinus infections

Cardiovascular

- □ Chest pain
- □ Palpitations
- □ Irregular heart beat
- □ Swelling of legs
- □ Swelling of feet
- □ Cold hands
- □ Cold feet

Constitutional

- □ Chills
- □ Fever
- □ Night sweats
- □ Weight gain (Unintentional)
- □ Weight loss (Unintentional)

Respiratory

- □ Chronic cough
- □ Oxygen use - day
- □ Oxygen use – night
- □ Oxygen use – continuous
- □ Shortness of breath
- □ Wheezing

Musculoskeletal

- □ Bone pain
- □ Cramps
- □ Joint pain
- □ Muscle loss
- □ Muscle pain
- □ Stiffness
- □ Weakness

Endocrine

- □ Always cold
- □ Always hot
- □ Excessive thirst
- □ Excessive Urination

Head / Face

- □ Headaches
- □ Migraines
- □ Facial Pain
- □ TMJ – left side
- □ TMJ – right side

Vision

- □ Blurred vision
- □ Double vision
- □ Farsighted
- □ Nearsighted
- □ Vision loss – left eye
- □ Vision loss – right eye

Skin / Hair / Nails

- □ Changes in hair
- □ Changes in nails
- □ Changes in skin color
- □ Dry skin
- □ Eczema
- □ Itching
- □ Recurrent rashes

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

NAME OF PERSON COMPLETING THIS FORM: _____

SIGNATURE: _____

DATE: _____