

**PATIENT QUESTIONNAIRE**

**LAST NAME:** \_\_\_\_\_ **FIRST NAME:** \_\_\_\_\_ **DATE:** M D Y

**ADDRESS:** \_\_\_\_\_

**TELEPHONE:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

**NAME OF YOUR REFERRING PHYSICIAN:** \_\_\_\_\_

**ADDRESS OF YOUR REFERRING PHYSICIAN:** \_\_\_\_\_

**TELEPHONE:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

**NAME AND ADDRESS OF YOUR PRIMARY PHYSICIAN:** \_\_\_\_\_

**LEVEL OF EDUCATION:** \_\_\_\_\_ **CURRENT OR PAST OCCUPATION:** \_\_\_\_\_

**WHAT IS YOUR CHIEF COMPLAINT(S)?** \_\_\_\_\_

**FOR HOW LONG?:** \_\_\_\_\_

**LIST ALL CURRENT MEDICATIONS (NAME, DOSAGE AND HOW FREQUENTLY YOU TAKE IT and DATE STARTED IF KNOWN):**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**LIST ALL CURRENT OR PREVIOUS MEDICAL PROBLEMS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**LIST OPERATIONS YOU HAVE HAD IN THE PAST:**

**LIST OTHER REASONS FOR HOSPITALIZATIONS:**

**LIST ALLERGIES:**

**PROVIDE AGES OF THE FOLLOWING RELATIVES AND NOTE IF THEY HAD ANY TREMOR, TICS, DYSTONIA, CHOREA , OTHER INVOLUNTARY MOVEMENTS, PARKINSON'S DISEASE, GAIT OR BALANCE PROBLEMS OR ANY OTHER NEUROLOGIC PROBLEMS:**

RELATIVE	CURRENT AGE	CHECK IF DECEASED OR AGE AT DEATH	MEDICAL/NEUROLOGIC HISTORY
Mother			
Father			
Brothers			
Sisters			
Sons			
Daughters			
Other relatives with movement or neurologic problem			

SOCIAL HISTORY:	PAST	PRESENT
TOBACCO		
ALCOHOL		
DRUGS		

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**REVIEW OF SYSTEMS: Do you presently have any of the following: (Please check YES or NO)**

	YES	NO	ELABORATE, IF YES...
<b>1. CONSTITUTIONAL</b>			
Weight change	<input type="checkbox"/>	<input type="checkbox"/>	
Sweats / Fever / Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	
<b>2. EYES</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Change in vision	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma / Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3. EARS, NOSE, THROAT</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Loss of hearing	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	
Nose bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
Hoarseness .	<input type="checkbox"/>	<input type="checkbox"/>	
Change in swallowing	<input type="checkbox"/>	<input type="checkbox"/>	
<b>4. RESPIRATORY</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
<b>5. CARDIOVASCULAR</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart attack / Chest pain/angina	<input type="checkbox"/>	<input type="checkbox"/>	
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	
Phlebitis or blood clots	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	
<b>6. GASTROINTESTINAL</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Reflux	<input type="checkbox"/>	<input type="checkbox"/>	
Liver Disease/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
Diarrhea/constipation / Bloody stools	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	
<b>7. ENDOCRINE SYSTEM</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>	
Hormone treatment / Menopause	<input type="checkbox"/>	<input type="checkbox"/>	
<b>8. BREAST/GENITAL</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Masses	<input type="checkbox"/>	<input type="checkbox"/>	
Genital infections	<input type="checkbox"/>	<input type="checkbox"/>	
<b>9. URINARY SYSTEM</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Urinary tract/bladder infections	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	
Incontinence / Trouble urinating	<input type="checkbox"/>	<input type="checkbox"/>	
<b>10. SKIN</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Rashes / Cancers			
<b>11. NEUROLOGIC</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Head injury	<input type="checkbox"/>	<input type="checkbox"/>	
Nerve damage	<input type="checkbox"/>	<input type="checkbox"/>	
<b>12. PSYCHIATRIC</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	
<b>13. MUSCULOSKELETAL</b>	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
OTHER Disorders or problems:	<input type="checkbox"/>	<input type="checkbox"/>	

\_\_\_ All other systems negative \_\_\_\_\_

I have reviewed the above document  
 NAME OF ATTENDING PHYSICIAN: \_\_\_\_\_

ATTENDING PHYSICIAN'S SIGNATURE: \_\_\_\_\_