CTNC Central Texas Neurology Consultants

Diseases of the Brain, Spine, Nerves and Muscles

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NEW PATIENT QUESTIONNAIRE

Name: _____ Appointment Date: _____

Birth Date: _____ Age: _____ Referred By: _____

What is the reason for the visit? _____

When did you first become aware of this problem? _____

Describe the problem: _____

Describe the duration and course of the problem *(continuous, intermittent, seconds, minutes, hours, etc.).* _____

What is the body part most affected? _____

Have you previously received a diagnosis for this problem? ☐ Yes ☐ No

If so, what was the diagnosis? _____

Who made the diagnosis? _____

What tests have been performed to aid this problem? _____

What treatments have you received for this problem? _____

What improves your problem *(medication, rest, etc.)*? _____

What worsens your problem *(exercise, lack of sleep, stress, etc.)*? _____

How has your problem interfered with your activities of daily living, such as bathing, feeding, or clothing yourself?

What is your occupation, and how has your problem interfered with it? _____

Who in your family has a similar problem? _____

Does anyone in your family have a neurological disease? If so, specify. _____

PLEASE CHECK THE APPROPRIATE ANSWERS

GENERAL HEALTH ☐ Excellent ☐ Good ☐ Fair ☐ Poor

OTHER ILLNESSES:

☐ Cancer, Specify: _____
☐ Heart Disease _____
☐ Kidney Disease _____
☐ Liver Disease _____
☐ Lung Disease _____
☐ Chronic Infection _____
☐ Mental Disorder _____
☐ Other _____

☐ High Blood Pressure
☐ Diabetes
☐ Thyroid Disease
☐ Arthritis
☐ Glaucoma
☐ Blood Disorder
☐ High Cholesterol
☐ Ulcer

FAMILY HISTORY *(DISEASES THAT RUN IN YOUR FAMILY)*:
List any family members that have the following diseases:

_____ Stroke
_____ Heart Disease
_____ High Blood Pressure
_____ Memory Loss
_____ Other

_____ Seizures
_____ Diabetes
_____ Cancer *(What kind?)*

OPERATIONS AND HOSPITALIZATIONS *(List Dates and Diagnosis)*:

ACCIDENTS AND INJURIES *(List Dates and Types of Injuries)*:

LIST ALL PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS YOU TAKE, ALONG WITH THE DOSES:

ALLERGIES OR UNUSUAL REACTIONS TO DYES OR MEDICATIONS:

HABITS:

	PRESENT	PAST	HOW MUCH
Tobacco	☐ Yes ☐ No	☐ Yes ☐ No	_____
Alcohol	☐ Yes ☐ No	☐ Yes ☐ No	_____
Exercise	☐ Yes ☐ No	☐ Yes ☐ No	_____
Drug Use	☐ Yes ☐ No	☐ Yes ☐ No	_____

LIST OF SYMPTOMS
PLEASE CHECK ALL THOSE WHICH APPLY

☐ Excessive weight gain _____ lb.in _____ months

☐ Excessive weight loss _____ lb.in _____ months

☐ Excessive sweating, ☐ hair change, or ☐ hot/cold insensitivity

☐ Prolonged sore throat, ☐ hoarseness, or ☐ difficulty swallowing

☐ Difficulty breathing or ☐ chronic cough

☐ Chest pain or ☐ irregular heart beat

☐ Abdominal pain, ☐ nausea, ☐ change in bowel habits or control

☐ Change in urination frequency, ☐ pain upon urinating, ☐ incontinence

☐ Change in menstrual cycle *(Women)* or Impotence *(Men)*

☐ Uncontrollable crying or laughing

☐ Change in hearing

☐ Change in sense of smell or taste

☐ Blurred vision

☐ Double vision

☐ Generalized weakness or fatigue *(all muscles)*

☐ Specific limb or muscle weakness – Specify: _____

☐ Decrease in muscle size – Specify: _____

☐ Involuntary movements – Check: ☐ Cramping ☐ Trembling ☐ Jerking ☐ Other

☐ Numbness – Specify where: _____

☐ Muscle pain or tenderness – Specify where: _____

☐ Memory loss

☐ Difficulty concentrating

☐ Depression

☐ Sleeping too much – average sleep per night: _____ hours

☐ Inability to sleep *(Insomnia)* – average sleep per night: _____ Hours

☐ Blackouts *(fainting spells)*

☐ Lightheaded – the feeling of almost passing out

☐ Vertigo – the feeling of the room or yourself spinning

☐ Seizures

☐ Headaches

☐ Neck stiffness or pain – shooting pain into arm(s)? ☐ Yes ☐ No

☐ Low back stiffness or pain – shooting pain into leg(s)? ☐ Yes ☐ No

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