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	_____

Review of Symptoms

Please check all those that apply.

☐Fever of _____ °F / ☐ Chills, ☐ Night Sweats
☐ Fatigue
☐ Weight gain of _____ lbs in _____ months
☐ Weight loss (unintentional) of _____ lbs in _____ months
☐ Blurred vision
☐ Eye drainage
☐ Eye pain
☐ Glasses /contacts
☐ Light sensitivity (photophobia)
☐ Double vision
☐ Ear pain
☐ Hearing problems
☐ Ringing in he ears (tinnitus)
☐ Nose bleeds (existaxis) - frequent
☐ Nasal congestion / drainage
☐ Dental issues, ☐ Dentures, ☐ Mouth sores
☐ Sore throat / ☐ Sore tongue / ☐ Hoareness
☐ Chest pain
☐ Rapid heart beat/ ☐ Irregular heart beat / ☐ Palpitations
☐ Dizziness
☐ Swelling (specify extremity below)

_____

☐ Varicose veins
☐ Chronic cough / ☐ New cough
☐ Breathing problems / ☐ Pain on breathing / ☐ Wheezing
☐ Abdonminal pain
☐ Acid reflux
☐ Trouble swallowing (dysphagia) / ☐ Pain in mouth
☐ Constipation / ☐ Diarrhea / ☐ Stool incontinence
☐ Nausea / ☐ Vomiting
☐ Blood in Stool / ☐ Dark tarry stool (melena)
☐ Impotence (men) / ☐ Change in menses (women)
☐ Frequent UTIs
☐Increased frequency of urination / ☐ Urgency / ☐ Urinary incontinence
☐ Nocturia (getting up at night): _____ times
☐ Urine stream change (hesitancy)
☐ Joint pain / ☐Joint stiffness
☐ Muscle Pain or tenderness - Specify below:

_____

☐ Back pain (☐ Shooting to legs)
☐ Neck pain (☐ Shooting to arms)
☐ Neck stiffness
☐ Atypical skin lesions / ☐ Rash / ☐ Itching
☐ Ataxia
☐ Headache
☐ Memory changes
☐ Numbness / tingling - Specify below:

_____

☐ Seizures
☐ Tremor / ☐ Cramping / ☐ Jerking / ☐ Other involutary movement:

_____

☐ Vertigo
☐ Generalized weakness (all muscles)
☐ Specific limb weakness:

_____

☐ Easy bruising / ☐ Easy bleeding
☐ Swollen lymph nodes
☐ Hair change / loss
☐ Heat / cold interlerance
☐ Excessive sweating
☐ Seasonal allergies
☐ Frequent upper respiratory infections
☐ Hives
☐ Depression / ☐ Anxiety
☐ Uncontrollable laughter / crying
☐ Stress
☐ Personality change
☐ Poor Concentration
☐ Current / Prior drug use:

_____

☐ Sleeping too much: _____ hours/night
☐ Sleeping too little: _____ hours/night
☐ Thoughts of self-harm