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: ______________________ ☐ High Blood Pressure
☐ Heart Disease ______________________ ☐ Diabetes
☐ Kidney Disease ______________________ ☐ Thyroid Disease
☐ Liver Disease ______________________ ☐ Arthritis
☐ Lung Disease ______________________ ☐ Glaucoma
☐ Chronic Infection ______________________ ☐ Blood Disorder
☐ Mental Disorder ______________________ ☐ High Cholesterol
☐ Other ______________________ ☐ Ulcer

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

______________ Stroke ______________ Seizures
______________ Heart Disease ______________ Diabetes
______________ High Blood Pressure ______________ Cancer *(What kind?)*
______________ Memory Loss
______________ Other ______________________

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