Be Mobile Neurology

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# New Patient Questionnaire

Date_____/____/_____ Name First_____ Last_____

DOB_____ Age _____ Sex: ☐Male ☐Female Ethnicity: ☐White ☐African-American
☐American Indian ☐Asian ☐Hispanic ☐Other(s)_____

## Chief Complaint

What is the reason for the visit? _____

What symptoms bother you the most? _____

_____

How long have you had these symptoms? _____

Goals of Today's Visit:

1. _____
2. _____

Have you seen another neurologist in the past for these symptoms? ☐ Yes ☐ No

Do you currently follow with a neurologist? ☐Yes ☐ No If yes, physician's name: _____

## Social History

Living Situation:☐Independent in Home ☐In Home with Assistance ☐Skilled Nursing Facility ☐Assisted Living

Do you feel safe in your current living situation? ☐Yes ☐No

Marital Status: ☐ Married ☐ Not Married ☐ Divorced ☐ Widow/Widower ☐ Live with Significant Other

Education (did you graduate?): ☐ High School ☐ Technical School ☐ College ☐ Graduate School

Occupation (job): _____ Retired? ☐Yes ☐No

Do/did you ever smoke? ☐Yes ☐No How long?_____Average packs per day_____if quit, when? _____

Do you ever drink alcohol? ☐Yes ☐No If yes, average amount consumed per day _____

Do/did you ever use?☐Marijuana ☐Cocaine ☐other drug/name_____

If yes to any, when and how long used? _____

Do you have children? ☐Yes ☐No If Yes, how many children? _____

Early Death of Any of Your Children ☐Yes ☐No Why? _____

## Allergies

| Medication | Reaction |
|---|---|
| 1. | |
| 2. | |

☐Food_____

☐Adhesive Tape ☐Latex ☐Betadine ☐Soaps _____

Other Allergies_____

## Past Medical History

| Problem | Onset | Current Treatment/Under Control Y/N |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## Surgical History

| Operation/Procedures, reason for procedure | Date |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |

## Family History

| Relative | Health Problems |
|---|---|
| Father | |
| Mother | |
| Sister(s) (number_____) | |
| Brother(s) (number_____) | |
| Children (number_____) | |
| Other (grandparents, grandchildren, etc.) | |

**Specific Neurologic Family History:** Are any of your blood relatives affected by? (check all that apply and on line indicate relative effected)

☐ Tremor_____
☐ Dementia_____
☐ Parkinson's _____
☐ Epilepsy/Seizures_____
☐ Mental Retardation_____
☐ Migraine_____
☐ Alcoholism/other addiction_____
☐ Other neurologic condition_____

**Medications (please list all of your medications including prescriptions, supplements, herbal products, vitamins, inhalers, injections and other over the counter medications)**

| Medication | Dosage | Frequency (times per day) | Length of Time on Medication |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |

Medications previously tried for my neurologic condition(s) only

| Medication | Dosage | Frequency (times per day) | Length of Time on Medication | Reason Discontinued |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |

Have you ever taken medication to raise your blood pressure? Such as midodrine, droxidopa(Orvaten or ProAmatine), droxidopa(Northera), fludrocortisone(Florinef). ☐Yes ☐No

If Yes, please list all medications tried _____

**Brain and Spine Imaging (including x-rays, CT Scans, MRIs, DATScans, PET Scans, etc)**

| Type of Scan | Reason | Results | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Review of Symptoms (**Please check all that apply)

**Constitutional**: ☐No Problems

☐Poor Energy ☐Fever ☐Fatigue ☐Change in Appetite ☐Excessive Daytime Sleepiness ☐ Sleep Problems

**Eyes:** ☐No Problems

☐Blurred Vision ☐Double Vision ☐Unexplained Decreased Vision ☐Glasses ☐Contacts

**Ears/Nose/Mouth/Throat:** ☐No Problems

☐Difficulty Smelling ☐Hoarse Voice ☐Dry Mouth ☐Ringing in Ears ☐Difficulty Swallowing

☐Discharge from Ears ☐Sinus Discharge ☐Hearing Impaired, if yes ☐Hearing Aid(s)

**Neurologic:** ☐ No Problems

☐Headache ☐Memory Loss/Difficulty ☐Slowed Thinking or Trouble Thinking ☐Tremors ☐Dizziness/Vertigo

☐Falling/Walking Difficulty ☐Poor Balance ☐Loss of Coordination ☐ Numbness/Tingling

**Psychiatric:** ☐ No Problems

☐Depressed ☐Anxious ☐Panic Attack ☐Hallucinations ☐Mood Changes

**Hematologic/Lymphatic**: ☐No Problems

☐Enlarged Lymph Nodes ☐Increased Bleeding ☐Increased Bruising ☐Limb Swelling

**Heart/Cardiovascular:** ☐No Problems

☐High Blood Pressure ☐Abnormal Heart/Rhythm ☐Angina/Chest Pain ☐Previous Heart Attack

☐Passing Out/Fainting ☐Blood Clots/Phlebitis (DVT) If Yes to above, when?_____

**Lungs/Respiratory:** ☐No Problems

☐Hyperventilation ☐Cold, Cough or Bronchitis now ☐Shortness of Breath ☐Wheezing

**Allergy/Immunology:** ☐No Problems

☐Milk ☐Pollen/Hay Fever ☐Frequent or unusual Infections_____

**Gastrointestinal - Stomach/Intestines/Liver:** ☐ No Problems

☐ Constipation ☐Abdominal Pain ☐Reflux/Heartburn ☐Frequent/Persistent Nausea ☐Diarrhea

☐Blood in Stool ☐Incontinence of Stool

**Genitourinary:** ☐No Problems

☐Increased Urge to Urinate ☐Increased Frequency of Urination ☐Urinary Retention

☐Incontinence of Urine ☐Blood in Urine ☐Miscarriages ☐Difficulty with Sexual Functioning

**Skin:** ☐No Problems

☐Hair Loss ☐Rashes ☐Changing Moles ☐Ulcers

**Endocrine:** ☐No Problems

☐Recent Weight Loss or Gain_____lbs. ☐Increased Thirst ☐Heart or Cold Intolerance ☐Irregular Menses

**Bones/Joints/Muscles:** ☐No Problems

☐Joint Pain ☐Joint Swelling ☐Weakness ☐Back/Neck Pain ☐Muscle Cramps

**Daily Activities and Care**

| | No problems | Difficult but no help needed | Some help needed | A lot of help needed | Cannot do |
|---|---|---|---|---|---|
| Bathing/showering | | | | | |
| Getting dressed | | | | | |
| Getting out of bed | | | | | |
| Walking | | | | | |
| Using Toilet | | | | | |
| Eating Meals | | | | | |
| Preparing Meals | | | | | |
| Grocery Shopping | | | | | |
| Housework | | | | | |
| Managing Money | | | | | |

When did you last drive?_____

Have you had any accidents in the last 2 years? ☐Yes ☐ No If yes how many accidents_____

Assistive Devices: Please list all assistive devices you regularly use at home or in the community_____

_____

Have you fallen during the last 12 months? ☐ Yes ☐ No If yes, average number of falls per month_____

Using an assistive device when you fell? ☐Yes ☐ No If yes, type of device_____

Was the fall the result of a freezing episode? ☐Yes ☐ No

Were you injured in any of the falls? ☐ Yes ☐ No If yes, please comment_____

_____

| | |
|---|---|
| Do you often feel isolated or lonely? | ☐ Yes ☐ No |
| Have you noticed changes in your ability to speak? | ☐ Yes ☐ No |
| Are you frequently asked to repeat yourself? | ☐ Yes ☐ No |
| Have you noticed changes in your ability to swallow? | ☐ Yes ☐ No |
| Do you cough or choke when you eat or drink? | ☐ Yes ☐ No |
| Do you avoid certain foods because of difficulty to chewing or swallowing? | ☐ Yes ☐ No |

**Therapies (**Are you receiving or have received recently?) ☐Physical Therapy ☐Occupational Therapy ☐Speech Therapy ☐Home Health Aide ☐Counseling/Psychotherapy

☐Have you participated in a support group related to your illness? If yes, indicate group_____

## Exposure History

Have you ever been exposed to toxins (pesticides, industrial chemical, heavy metals, etc.)?

☐Yes ☐ No If Yes Explain_____

_____

**Have you have ever taken any of the following medications:**

- ☐ carbidopa/levodopa(Sinemet )
- ☐ carbidopa/levodopa/entacapone (Stalevo)
- ☐ pramipexole (Mirapex)
- ☐ ropinirole (Requip)
- ☐ apomorphine (Apokyn)
- ☐ selegiline (Edepryl, Zelapar)
- ☐ rasagiline (Azilect)
- ☐ amantadine (Symmetrel)
- ☐ trihexyphenidyl (Artane)
- ☐ benzotropine (Cogentin)
- ☐ tetrabenazine (Xenazine)
- ☐ baclofen (Lioresal)
- ☐ clonazepam (Klonopin)
- ☐ propranolol (Inderal)
- ☐ primidone (Mysoline)
- ☐ topiramate (Topamax)
- ☐ gabapentin (Neurontin)
- ☐ metoclopramide (Reglan)
- ☐ haloperidol (Haldol)
- ☐ pimozide (Orap)
- ☐ promethazine (Phenergan)
- ☐ prochloperazine (Compazine)
- ☐ chlorpromazine (Thorazine)
- ☐ thioridazine (Mellaril)
- ☐ thiothixene (Nevane)
- ☐ fluphenazine (Prolixin)
- ☐ perphenazine (Trilafon, Etrafon, Triavil)
- ☐ trifluoperzine (Stelazine)
- ☐ aripiprazole (Abilify)
- ☐ risperidone (Risperdal)
- ☐ quetiapine (Seroquel)
- ☐ ziprasidone (Geodon)