Neurology&
Neurodiagnostics

407 250 3290 PHONE

NEW PATIENT QUESTIONNAIRE Date _____

PATIENT IDENTIFICATION

Form completed by: ☐ Patient ☐ Caregiver ☐ Other _____

I. PERSONAL PROFILE:

Full Legal Name: _____ SS # _____

Birth Date: _____ Age: _____ Birth Place: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated # of Marriages: _____

Patient's Native (1st) Language: ☐ English ☐ Spanish ☐ Other _____

Handedness: ☐ Right-handed ☐ Left-handed ☐ Ambidextrous (uses both)

Who does the patient live with? _____

In which country was the patient born? _____

Education: Highest Level (degree or years) _____

Employment: ☐ Never Employed ☐ Full-time Part-time Retired Disabled: Due to _____

Present Occupation/Profession: _____

Does the patient drive? ☐ No ☐ Yes

CHIEF COMPLAINT: _____

CURRENT SYMPTOMS: Onset / Duration / Localization / Description / Intensity / Exacerbators / Progression, etc.

_____

_____

_____

_____

_____

_____

_____

_____

_____

II. PAST MEDICAL HISTORY List medical problems and treatments as well as any pertinent data.

YEAR	DIAGNOSES	TREATMENT / COMMENTS

Do you smoke ? _____ Do you drink alcohol ? _____

How many cigarettes do you smoke each day? _____

How much alcohol (beer/wine/liquor) do you drink each day?

_____

Have you ever used narcotics or other addictive drugs? _____

_____

Physician's Comments:

_____

_____

_____

_____

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III. FAMILY HISTORY (check (✓) relationship as indicated)

RELATIONSHIP	AGE IF LIVING	AGE AT DEATH	ILLNESSES AND/OR CAUSE OF DEATH INCLUDE NEUROLOGIC DISORDERS
Father			
Mother			
Siblings Brothers (✓) Sisters (✓)			
Grandparents			
Uncles / Aunts			
Cousins			
Children Sons (✓) Daughters (✓)			

Have YOU, ever had any of the following problems?

☐Yes ☐No Seizures

☐Yes ☐No Strokes

☐Yes ☐No Drug abuse

Diabetes: ☐Insulin Dependent ☐Adult Onset

High Blood Pressure: ☐Controlled by Medication ☐Not Medicated

Cancer: Type _____ Treatment _____ Year____

Type _____ Treatment _____ Year____

Type _____ Treatment _____ Year____

Has patient had an MRI or CT ? Yes ☐ No ☐

When, where ? _____

Have YOU, ever had any of the following problems?

1. ☐Yes ☐No Coronary heart disease/Heart Attack/Angina
2. ☐Yes ☐No Enlarged Heart/Congestive Heart Failure
3. ☐Yes ☐No High Blood Pressure/Hypertension
4. ☐Yes ☐No Kidney or Bladder Trouble (Bladder Incontinence)
5. ☐Yes ☐No Tuberculosis
6. ☐Yes ☐No Venereal Disease (Syphilis, Gonorrhea, Chlamydia) or PID
7. ☐Yes ☐No Herpes Type I or II
8. ☐Yes ☐No HIV Infections/AIDS
9. ☐Yes ☐No Blood Clots In Your Legs or Lungs

List any other serious illnesses or injuries you have had (give dates):

_____

_____

Physician's Comments:

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Please list all DISEASES and HOSPITALIZATIONS for serious injuries and major surgeries
From the most recent to earliest in life:

Year		Year	

CURRENT MEDICATIONS: Please list all currently prescribed medications, vitamins, suplements, and non-prescribed agents:

Name of drug	Dosage	# of pills per day	Prescribed by

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Drug Allergies:

Which drug(s)? *(please include reaction):* _____

_____

_____

Food Allergies: _____

IV. REVIEW OF SYSTEMS (Continued - Please check boxes beside current symptoms of the patient)

GENERAL
- ❑ Chills/fever
- ❑ Loss of Appetite
- ❑ Loss of Sleep
- ❑ Change in Weight
- ❑ Loss of Energy
- ❑ Sweats
- ❑ Daytime Sleepiness
- ❑ Tiredness/Fatigue

SKIN
- ❑ Lumps or Growths
- ❑ Bruise Easily
- ❑ Rash

NEUROLOGIC
- ❑ Muscle Pain
- ❑ Head Injury
- ❑ Stroke
- ❑ Tremors
- ❑ Fainting/Blackouts
- ❑ Seizures/Convulsions
- ❑ Numbness/Tingling
- ❑ Headaches
- ❑ Weakness/Paralysis
- ❑ Dizziness/Lightheaded
- ❑ Stumbling
- ❑ Memory Loss

PSYCHIATRIC
- ❑ Personality Change
- ❑ Confusion
- ❑ Depression
- ❑ Nervousness
- ❑ Delusions
- ❑ Hallucinations

VISION
- ❑ Blurred Vision
- ❑ Double Vision
- ❑ Cataracts
- ❑ Glasses
- ❑ Contact Lenses
- ❑ Glaucoma
- ❑ Eye Injury

EARS/NOSE/MOUTH/THROAT
- ❑ Hearing Loss
- ❑ Ringing in Ears
- ❑ Bleeding Gums
- ❑ Trouble Swallowing
- ❑ Hoarseness
- ❑ Nasal Discharge
- ❑ Snoring

CARDIOVASCULAR
- ❑ Chest Pain
- ❑ Blood Pressure Problems
- ❑ Irregular Heartbeat

RESPIRATORY
- ❑ Shortness of Breath
- ❑ Persistant Cough
- ❑ Coughing Up Blood
- ❑ Asthma or Wheezing
- ❑ Bronchitis

GASTROINTESTINAL
- ❑ Ulcers
- ❑ Black Tarry Stool
- ❑ Constipation
- ❑ Diarrhea
- ❑ Nausea
- ❑ Frequent Vomiting
- ❑ Abdominal Pain
- ❑ Vomiting Blood
- ❑ Heartburn
- ❑ Rectal Bleeding

MUSCULOSKELETAL
- ❑ Joint Pain
- ❑ Joint Stiffness or Swelling
- ❑ Bone Pain
- ❑ Muscle Pain or Cramps
- ❑ Weakness of Muscles
- ❑ Back Pain
- ❑ Difficulty Walking

ENDOCRINE
- ❑ Thyroid Disease
- ❑ Diabetes

BLOOD / LYMPH
- ❑ Bleeding or Brusing Tendency
- ❑ Anemia
- ❑ Past Blood Transfusions
- ❑ Enlarged Glands

GENITO-URINARY
- ❑ Lack of Bladder or Bowel Control
- ❑ Kidney Stones

Males
- ❑ Erection Difficulties

Reviewed by _____

BRING THIS **COMPLETED** FORM THE DAY OF YOUR APPOINTMENT