

SOUTH COAST NEUROLOGY

Patient Questionnaire

Please Print Clearly

Name: _____ Date: _____ Age: _____

Specific reason for visit today (max 2): _____

Date of Last Physical Examination: _____ Date of Last Menstrual Cycle: _____

Date of Onset (when symptoms began): _____ Allergies: _____

Current medications (include dosage and direction): _____

Tobacco usage: ___ yes ___ no. If yes, how much? _____ Employment: _____

Alcohol usage: ___ yes ___ no. If yes, # of drinks weekly? ___ Highest level of education: _____

Medical History: YOU MUST COMPLETE THIS SECTION IF YOU ARE SEEING THE PROVIDER FOR THE FIRST TIME.

*Please check all that applies either to you or your family and give specific details.

	Patient	Family	Details/Type		Patient	Family	Details/Type
Accident:	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Disease:	<input type="checkbox"/>	<input type="checkbox"/>	_____
ADHD:	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning Disability:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis:	<input type="checkbox"/>	<input type="checkbox"/>	_____	Liver Disease:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma:	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lung Disease:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Disorder:	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mental Illness:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer:	<input type="checkbox"/>	<input type="checkbox"/>	_____	Migraine:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dementia:	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neurological Disease:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression:	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizure:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes:	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sinusitis:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Disorder:	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin Disease:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glasses/contacts:	<input type="checkbox"/>	<input type="checkbox"/>	_____	Spine Disease:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head Trauma:	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach Disease:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing Disorder:	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease:	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Disease:	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol:	<input type="checkbox"/>	<input type="checkbox"/>	_____	Surgery:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension:	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other medical/illness history:	_____		

Review of Systems: *Please check any **CURRENT** symptoms you are experiencing and/or what brought you in today.

Neurology Visit:

General:

- Appetite Loss
- Chills
- Dietary Changes
- Fatigue
- Fever
- Lethargy
- Night Sweats
- Weight change gained ___ lbs
 loss ___ lbs

Skin:

- Bruising
- Excessive Sweating
- Hair Loss
- Hives
- Itching
- New Lesions
- Rash

HEENT:

- Headache
- Head Injury
- Blurred Vision
- Double Vision
- Eye Pain
- Visual Disturbances
- Decreased Hearing
- Ear Pain
- Ringing in the Ears
- Vertigo
- Nose Bleed
- Nasal Congestion
- Sinus Pain
- Hoarseness
- Voice Changes
- Decreased sense of taste

Neck:

- Neck Pain
- Neck Stiffness
- Swollen Glands

Cardiovascular:

- Chest Pain
- Fainting
- Leg Cramps
- Palpitations
- Rapid Heart Rate
- Shortness of Breath
- Swelling of Extremities

Musculoskeletal:

- Back Pain
- Decreased Range of Motion
- Joint Pain
- Joint Redness
- Joint Stiffness
- Joint Swelling
- Muscle Atrophy
- Muscle Cramps
- Muscle Pain
- Muscle Weakness

Neurological

- Attention Deficit
- Auras
- Decreased Memory
- Difficulty Speaking
- Dizziness
- Easily Distracted
- Fasciculation
- Fainting
- Headaches
- Hyperactivity

Neurological: cont.

- Loss of Consciousness
- Numbness
- Seizures
- Spinning Sensation
- Tremor
- Visual Changes
- Weakness
- Tingling

Psychiatric:

- Anxiety
- Change in Sleep Pattern
- Depression
- Early Awakening
- Easily Irritated
- Fearful
- Frequent crying
- Impaired Cognitive Function
- Inability to Concentrate
- Insomnia
- Memory Loss
- Mood Changes
- Panic Attacks
- Suicidal Ideation

Endocrine:

- Appetite Changes
- Cold Intolerance
- Hair Changes
- Sexual Dysfunction