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# NEUROLOGY NEW PATIENT QUESTIONNAIRE

Name _____ Date of Birth _____ Age: _____

Home Address _____ City _____ State ___ Zip_____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ SSN _____ Sex: □ Male □ Female

Occupation _____ Martial Status _____ Children: □Yes #____ □ No

Referring Doctor _____ Address _____

_____ Phone _____ Email _____

Emergency Contact _____ Phone _____ Relationship _____

**List Doctors to Correspond with:**

NAME ADDRESS PHONE EMAIL

_____

_____

_____

_____

**Pharmacy Information:**

Name_____ Phone _____ Address_____

_____

**What is the reason for today's visit?**

_____

_____

_____

_____

_____

## Social History

### Smoking:

Do you Smoke (if yes how many cigarettes daily)? □ Yes _____ □ No
If "No", have you ever smoked (if so for how long and when did you stop? _____

### Alcohol Use:

Do you drink alcohol (if yes how often, how much, and your drink(s) of choice)? □Yes □ No

_____

### Illicit Drug Use:

| Drug | How Often | How Much | Current or Past Use |
|---|---|---|---|
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### Education:

Number of school years completed? (Please circle)

1 2 3 4 5 6 7 8 9 10 11 12 | Post Secondary ( Associates / Bachelors) | Higher

### Family History (limit family to: parents, siblings, aunts, and uncles):

| Condition | Family Member | Alive or Deceased (if deceased at what age) |
|---|---|---|

## Patient Surgical History:

| Type of Surgery/Procedure | Date | Doctor |
|---|---|---|
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## Current Medications:

| Medicine | Dosage | Frequency | Date Started | Prescribing Doctor |
|---|---|---|---|---|

## Medication Allergies:

| Medicine | Type of Reaction | Treatment |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## Other Allergens:

| Type | Reaction | Treatment |
|---|---|---|

## Past Medical History:

| CONDITION | DATE OF ONSET | TREATMENT HISTORY (active or never treated) |
|---|---|---|
| □ Coronary Artery Disease | | |
| **(State Condition(s))** | | |
| □ COPD | | |
| **(State Cause)** | | |
| □ Hypertension | | |
| □ High Cholesterol | | |
| □ Diabetes: Type I or II | | |
| □ Atrial Fibrillation (Afib) | | |
| □ Stroke | | |
| □ Seizures | | |
| □ Depression | | |
| □ Nasal Fracture | | |
| □ Mandibular malformation, fracture, infection or surgery | | |
| □ Other | | |
| | | |
| | | |

## Review of Systems

| | | |
|---|---|---|
| □ Headache | | |
| □ Palpitations /Chest Pain | | |
| □ Shortness of Breath | | |
| □ Neck Pain | | |
| □ Back Pain | | |
| □ Double Vision | | |
| □ Loss of Vision | | |
| □ Post Nasal Drip | | |
| □ Blurred Vision | | |
| □ Weakness | | |
| □ Tingling | | |
| □ Numbness | | |
| □ Anxiousness | | |
| □ Weight Gain | | |
| □ Fevers / Chills | | |
| □ Snoring | | |
| □ Hallucinations | | |
| □ Nausea / Vomiting | | |
| □ Memory Loss | | |
| □ Falls / Unsteadiness | | |
| □ Insomnia | | |
| □ Weight Gain | | |
| □ Other | | |
| | | |
| | | |

## Rest and Sleep:

Do you suffer from any of the following (select all that apply)?

□ Snoring
□ Excessive daytime sleepiness / Fatigue
□ Difficulty breathing
□ Difficulty gasping while asleep
□ Dry mouth in the mornings
□ Difficulty falling or staying asleep
□ Kicking/punching while asleep
□ Difficulty choking
□ Uncontrolled urge to move your legs at night
□ Frequent urination at night-time

## Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 = would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

| **Situation** | Chance of dozing |
|---|---|
| Sitting and reading …… | |
| Watching TV …….. | |
| Sitting, inactive in a public place (e.g. a theatre or meeting) ……. | |
| As a passenger in a car for an hour without a break …….. | |
| Lying down to rest in the afternoon when circumstances permit …….. | |
| Sitting and talking to someone …….. | |
| Sitting quietly after a lunch without alcohol ……. | |
| In a car, while stopped for a few minutes in the traffic ……. | |
| Total …… | |

| Score: | |
|---|---|
| 0-10 | Normal range |
| 10-12 | Borderline |
| 12-24 | Abnormal |