Pacific Crest Neurology

New Patient Questionnaire

Name: **Reason for Visit:**

Primary Care: **Pharmacy:**

Medical Problems: Check all that apply

ADHD_____
Alzheimer's_____
Anxiety_____
A-Fib_____
Blood Clot DVT_____
Blood Clot PE_____
Carpal Tunnel_____
Congestive Heart Failure_____
Coronary Artery Disease_____
Diabetes _____
Epilepsy_____
Headaches _____
Heart Attack_____
Herpes_____
HIV_____
Hypertension_____
Memory Loss_____
Migraine_____
Multiple Sclerosis _____
Parkinson's Disease_____
Neuropathy_____
Restless Leg Syndrome_____
Sleep Apnea_____
Spinal Stenosis_____
Stroke_____

Surgical History: Check all that apply and list date if known

Pace Maker: ______________________
Cervical Diskectomy:_______________
Deep Brain Stimulator:_____________
Craniotomy:______________________
Laminectomy:_____________________
Spinal Cord Stim:______________
Baclofen Pump:_______________
Diskectomy:__________________
Spinal Fusion: ________________
VNS: ________________________

Allergies: List reaction: Medication(s):____

Family History: List only immediate family members below

Adopted: _________________________
Ataxia:___________________________
Huntington's:_____________________
Migraine_________________________
Multiple Sclerosis_________________
Neuropathy_____________________
Aneurysm________________________
Parkinsonism_________________
Seizure_____________________
Stroke_____________________
Cancer_____________________
Heart Attack____________________
Alzheimer's/Dementia_______________
Brain Tumor_____________________

Marital Status:

Married_____
Divorced_____
Single_____
Widowed_____
Significant Other_____

Education Level: Circle

High School College
Occupation:___________________
(If retired please indicate previous occupation.)

Risk Factors: Check all that apply

Drug Use:
None_____

Marijuana:
Medical_________________
Recreational_________________

Caffeine Use:
Cups per day__________

Alcohol Use:
Drinks per day__________

Living History:
Independent _____________
Assisted Living____________
Foster ___________________

Tobacco: Circle

Never or Former Current everyday smoker Current occasional smoker

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New Patient Questionnaire

If you are CURRENTLY experiencing any of the following symptoms/conditions, please circle "Y":

Systemic Symptoms:

Fever:	Y	N
Feeling Tired or Poorly:	Y	N
Edema:	Y	N
Night Sweats:	Y	N
Chills:	Y	N

HEENT symptoms:

Headache:	Y	N
Double vision:	Y	N
Ringing in ears:	Y	N
Difficulty swallowing:	Y	N

Cardiovascular:

Chest pain:	Y	N
Palpitations:	Y	N

Pulmonary:

Cough:	Y	N
Shortness of breath:	Y	N

Gastrointestinal Symptoms:

Nausea:	Y	N
Vomiting:	Y	N
Diarrhea:	Y	N

Genitourinary Symptoms:

Dysuria (pain with urination):	Y	N
Increased urinary frequency:	Y	N

Endocrine:

Excess thirst:	Y	N
Heat intolerance:	Y	N
Cold intolerance:	Y	N

Skin:

Rashes:	Y	N
Pruritis (itchy skin):	Y	N
Skin lesion:	Y	N

Hematological:

Easy bruising:	Y	N
Easy bleeding:	Y	N

Musculoskeletal:

Back pain:	Y	N
Muscle ache:	Y	N
Muscle weakness:	Y	N

Neurological:

Numbness:	Y	N
Tingling:	Y	N
Dizziness:	Y	N
Headache:	Y	N
Vertigo (spinning):	Y	N
Tremor:	Y	N
Fainting:	Y	N
Seizures:	Y	N
Weakness:	Y	N

Psychological Symptoms:

Depression:	Y	N
Anxiety:	Y	N
Sleep disturbance:	Y	N

ANY OTHER SYMPTOMS NOT LISTED ABOVE:

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COMMENTS FOR PHYSICIAN OR STAFF:____

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