PHYSICIANS' CLINIC of Iowa, P.C.

# NEUROLOGY & SLEEP MEDICINE NEW PATIENT QUESTIONNAIRE

Date of first appointment ____________ First Name ____________ Last Name ____________

Date of Birth ____________ Age ______ Gender: ☐ Male ☐ Female If female, are you pregnant? ☐ Yes ☐ No

Handedness: ☐ Right ☐ Left ☐ Ambidextrous

Main reason for your visit: ____________

Describe briefly your present symptoms (quality, location, timing, other problems): ____________

____________

____________

Please list the names of other health care providers you have seen for this problem: ____________

____________

Date symptoms began (approximate) ____________ Diagnosis given? ____________

Previous treatment for this problem (include physical therapy, surgery, and medications) ____________

____________

____________

**REVIEW OF SYSTEMS:** Please check any new symptoms you have experienced in the last MONTH.

***Constitutional/General***
- ☐ Yes ☐ No Loss of Appetite
- ☐ Yes ☐ No Chills
- ☐ Yes ☐ No Fever
- ☐ Yes ☐ No Heavy Sweating/Night Sweats
- ☐ Yes ☐ No Sleep Disturbances
- ☐ Yes ☐ No Unexplained Weight Loss/Gain
- Other: ____________

***Eyes***
- ☐ Yes ☐ No Double Vision
- ☐ Yes ☐ No Blurry Vision
- ☐ Yes ☐ No Wear Glasses
- ☐ Other: ____________

***Ear/Nose/Throat***
- ☐ Yes ☐ No Mouth Sores
- ☐ Yes ☐ No Hearing Loss
- ☐ Yes ☐ No Nasal Congestion/Sinus Issues
- ☐ Yes ☐ No Sore Throat
- ☐ Other: ____________

***Respiratory***
- ☐ Yes ☐ No COPD
- ☐ Yes ☐ No Recurrent Respiratory Infections
- ☐ Yes ☐ No Chest Pain
- ☐ Yes ☐ No Cough
- ☐ Yes ☐ No Shortness of Breath
- ☐ Yes ☐ No Wheezing
- ☐ Other: ____________

***Cardiovascular***
- ☐ Yes ☐ No Varicose Veins
- ☐ Yes ☐ No Heart Attack
- ☐ Yes ☐ No Irregular Heartbeat
- ☐ Yes ☐ No Palpitations
- ☐ Yes ☐ No Swelling Feet, Ankles, Legs
- ☐ Other: ____________

***Gastrointestinal***
- ☐ Yes ☐ No Abdominal Pain
- ☐ Yes ☐ No Blood in Stools
- ☐ Yes ☐ No Change in Bowel Habits
- ☐ Yes ☐ No Constipation
- ☐ Yes ☐ No Diarrhea
- ☐ Yes ☐ No Swallowing Difficulties
- ☐ Yes ☐ No Indigestion/Heartburn
- ☐ Yes ☐ No Nausea
- ☐ Yes ☐ No Rectal Bleeding
- ☐ Yes ☐ No Vomiting
- ☐ Other: ____________

***Psychological***
- ☐ Yes ☐ No Anxiety
- ☐ Yes ☐ No Depression
- ☐ Other: ____________

***Genitourinary***
- ☐ Yes ☐ No Loss of Urinary Control
- ☐ Yes ☐ No Enlarged Prostate
- ☐ Yes ☐ No Difficulty Urinating
- ☐ Yes ☐ No Urinary Frequency
- ☐ Yes ☐ No Painful Urination
- ☐ Other: ____________

***Skin***
- ☐ Yes ☐ No Discoloration
- ☐ Yes ☐ No Itching
- ☐ Yes ☐ No Lumps or Masses
- ☐ Yes ☐ No Skin Rash
- ☐ Other: ____________

***Musculoskeletal***
- ☐ Yes ☐ No Back Pain
- ☐ Yes ☐ No Limitation of Motion
- ☐ Yes ☐ No Pain with Walking
- ☐ Yes ☐ No Neck Pain
- ☐ Yes ☐ No Joint Pain
- ☐ Yes ☐ No Joint Swelling
- ☐ Other: ____________

***Endocrine***
- ☐ Yes ☐ No Feeling Tired (Fatigue)
- ☐ Yes ☐ No Temperature Intolerance
- ☐ Yes ☐ No Excessive Thirst/Fluid Intake
- ☐ Yes ☐ No Hot Flashes
- ☐ Other: ____________

***Hematologic/Lymphatic***
- ☐ Yes ☐ No Blood Clotting Problem
- ☐ Yes ☐ No Bleeding Tendencies
- ☐ Yes ☐ No Easy Bruising
- ☐ Yes ☐ No Swollen Glands
- ☐ Other: ____________

***Neurological***
- ☐ Yes ☐ No Dizzy Spells
- ☐ Yes ☐ No Unsteady Gait
- ☐ Yes ☐ No Headache
- ☐ Yes ☐ No Feeling Weak
- ☐ Yes ☐ No Convulsions/Seizures
- ☐ Yes ☐ No Numbness/Tingling
- ☐ Yes ☐ No Tremors
- ☐ Other: ____________

**PAST MEDICAL HISTORY:** *(please check all that apply and state when the problem started)*

☐ Yes ☐ No Headaches ____________________
☐ Yes ☐ No Atrial Fibrillation/Flutter ___________
☐ Yes ☐ No Tonsillectomy ____________________
☐ Yes ☐ No Seizures ____________________
☐ Yes ☐ No Anxiety ____________________
☐ Yes ☐ No Drug Addiction ____________________
☐ Yes ☐ No Back or Joint Problems ___________
☐ Yes ☐ No Depression ____________________
☐ Yes ☐ No Alcohol Addiction ____________________
☐ Yes ☐ No Chronic Pain Syndrome ___________
☐ Yes ☐ No Nasal/Throat Surgery ___________

Other significant illnesses or infections: ____________________________________________

**FAMILY HISTORY:** Has any member of your family (not to include spouse or in-laws) ever had the following conditions. If yes, indicate family member.

| | | Condition | Family Member |
|---|---|---|---|
| ☐ Yes | ☐ No | Dementia | |
| ☐ Yes | ☐ No | Early Cardiac Death (<65 years old) | |
| ☐ Yes | ☐ No | Insomnia | |
| ☐ Yes | ☐ No | Narcolepsy | |
| ☐ Yes | ☐ No | Obstructive Sleep Apnea | |
| ☐ Yes | ☐ No | Parkinson's Disease | |
| ☐ Yes | ☐ No | Restless Leg Syndrome | |
| ☐ Yes | ☐ No | Seizures | |
| ☐ Yes | ☐ No | Sleep Walking | |

Other conditions: ____________________________________________

**SLEEP HISTORY:**

☐ Yes ☐ No Feel sleepy during the day
☐ Yes ☐ No Snore
☐ Yes ☐ No Awakened by your own snoring
☐ Yes ☐ No Wake up gasping for air
☐ Yes ☐ No Stop breathing while asleep
☐ Yes ☐ No Have restless sleep
☐ Yes ☐ No Have limb jerks while asleep
☐ Yes ☐ No Walk while asleep
☐ Yes ☐ No Talk while asleep
☐ Yes ☐ No Episodes of confusion
☐ Yes ☐ No Have vivid dreams/nightmares
☐ Yes ☐ No Have heartburn or gastric reflux
☐ Yes ☐ No Have morning headaches
☐ Yes ☐ No Have nighttime wheezing
☐ Yes ☐ No Wake up with a dry mouth
☐ Yes ☐ No Have an urge to move your legs
☐ Yes ☐ No Have a crawling feeling in your legs
☐ Yes ☐ No Usually dream during naps
☐ Yes ☐ No Feel muscle weakness with emotion (laughter, anger, etc)
☐ Yes ☐ No See/hear things when waking/falling asleep
☐ Yes ☐ No Feel like you can't move when waking/falling asleep

Do you work? ☐ Yes ☐ No (If no, please still complete your typical bedtime and rise time, as well as how long it typically takes you to fall asleep.)

What is your typical sleep schedule on **work** days? Bedtime: ____________ AM / PM Rise Time: ____________ AM / PM

What is your typical sleep schedule on **non-work** days? Bedtime: ____________ AM / PM Rise Time: ____________ AM / PM

How long does it take you to fall asleep on **work** days? ____________ On **non-work** days? ____________

If you have difficulty falling asleep, do you? ☐ Watch TV ☐ Read ☐ Toss & Turn ☐ Worry

Any other activities you do while trying to fall asleep? ____________________________________________

How many times do you wake up at night?____________ How long does it take you to go back to sleep?____________

Do you wake up feeling tired? ☐ Yes ☐ No Do you nap or doze off during the day? ☐ Yes ☐ No Are your naps refreshing? ☐ Yes ☐ No

Have you had a sleeping problem diagnosed in the past? ☐ Yes ☐ No

If yes, what was the problem and what treatment was recommended?____________________________________________

____________________________________________

**EPWORTH SLEEPINESS SCALE:** Please estimate your risk of falling asleep in the following situations, using the scale below:

| Situation | Chance of Dozing |
|---|---|
| Sitting and reading | |
| Watching TV | |
| Sitting inactive in a public place (theater or meeting) | |
| 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 traffic | |
| As a passenger in a car for an hour without a break | |
| TOTAL | |

0 = No chance of dozing
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Patient Signature: ____________________________________________ Date: ____________

Provider Signature: ____________________________________________ Date: ____________

*This form is destroyed after the information is entered and verified in the patient's electronic health record.*