PHYSICIANS' CLINIC
of Iowa, P.C.

NEUROLOGY 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) _____

_____

_____

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

☐ Yes ☐ No Headaches _____ ☐ Yes ☐ No Chronic Pain Syndrome _____ ☐ Yes ☐ No Depression _____

☐ Yes ☐ No Seizures _____ ☐ Yes ☐ No Atrial Fibrillation/Flutter _____ ☐ Yes ☐ No Drug Addiction _____

☐ Yes ☐ No Back or Joint Problems _____ ☐ Yes ☐ No Anxiety _____ ☐ Yes ☐ No Alcohol Addiction _____

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.

		Family Member
☐ Yes ☐ No	Anxiety	_____
☐ Yes ☐ No	Dementia	_____
☐ Yes ☐ No	Depression	_____
☐ Yes ☐ No	Epilepsy	_____
☐ Yes ☐ No	Migraine Headaches	_____
☐ Yes ☐ No	Obstructive Sleep Apnea	_____

		Family Member
☐ Yes ☐ No	Polyneuropathy	_____
☐ Yes ☐ No	Parkinson's Disease	_____
☐ Yes ☐ No	Restless Leg Syndrome	_____
☐ Yes ☐ No	Stroke or TIA	_____
☐ Yes ☐ No	Tremor	_____

Other conditions: _____

SLEEP HISTORY:

☐ Yes ☐ No Do you have trouble sleeping?

☐ Yes ☐ No Do you have insomnia?

☐ Yes ☐ No Do you snore?

☐ Yes ☐ No Have you ever been told you stop breathing while you sleep?

☐ Yes ☐ No Do you have a headache when you wake up in the morning?

☐ Yes ☐ No Are you tired when you wake in the morning?

☐ Yes ☐ No Do you get sleepy during the day when things are quiet?

☐ Yes ☐ No Do you get sleepy during the day when sitting or reading?

☐ Yes ☐ No Do you get sleepy when watching television?

☐ Yes ☐ No Do you get sleepy while driving?

☐ Yes ☐ No Do you have heartburn at night?

☐ Yes ☐ No Do you have a crawling, uncomfortable, restless feeling in your legs when you lay down or rest?

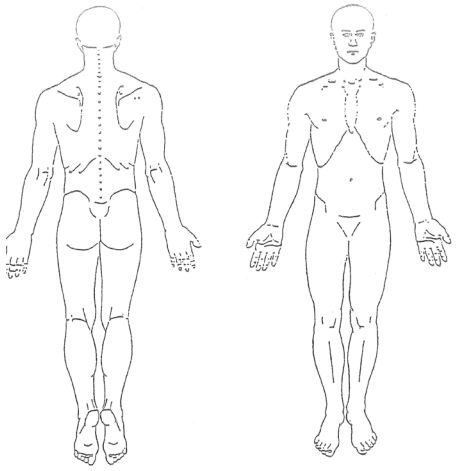
☐ Yes ☐ No Does it go way if you move your feet or get up and walk?

Please mark on these drawings the present location of your symptoms using the following key:

Pain

Pins & Needles

Numbness



If you missed work, what was your last day worked? _____

Using a scale from 1-10, with 0=No Pain and 10=the most pain you have ever experienced, please answer the following questions:

What is your current level of pain?	1	2	3	4	5	6	7	8	9	10
What is the worst this pain has been?	1	2	3	4	5	6	7	8	9	10
What is the best this pain has been?	1	2	3	4	5	6	7	8	9	10

What makes your pain better? ☐ Rest ☐ Heat ☐ Ice ☐ Medicine ☐ Hot Bath ☐ Exercise ☐ Massage ☐ Manipulation

What medications have you used? _____

What activity would you like to do, but cannot because of pain? _____

When do you notice most of your pain? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

What aggravates your pain? ☐ Sitting ☐ Bending ☐ Standing ☐ Driving ☐ Walking ☐ Coughing ☐ Lying Down ☐ Straining ☐ Putting on Shoes ☐ Riding in a Car ☐ Light ☐ Sound

Other: _____

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

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

Other: _____

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

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

Respiratory
- ☐ Yes ☐ No Cough
- ☐ Yes ☐ No COPD
- ☐ Yes ☐ No Wheezing
- ☐ Yes ☐ No Recurrent Respiratory Infections
- ☐ Yes ☐ No Shortness of Breath
- ☐ Other: _____

Cardiovascular
- ☐ Yes ☐ No Chest Pain or Discomfort
- ☐ Yes ☐ No Swelling Feet, Ankles, Legs
- ☐ Yes ☐ No Irregular Heartbeat
- ☐ Yes ☐ No Heart Attack
- ☐ Yes ☐ No Palpitations
- ☐ Yes ☐ No Varicose Veins
- ☐ Other: _____

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

Psychological
- ☐ Yes ☐ No Depression
- ☐ Yes ☐ No Anxiety
- ☐ Other: _____

Genitourinary
- ☐ Yes ☐ No Painful urination
- ☐ Yes ☐ No Urinary Frequency
- ☐ Yes ☐ No Loss of Urinary Control
- ☐ Yes ☐ No Enlarged Prostate
- ☐ Yes ☐ No Difficulty Urinating
- ☐ Other: _____

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

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

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

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

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

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____