New Patient Information Questionnaire

Name:______________________________________ Date:__________________

Email:____

Primary Care Physician(required):______________________________

Referring Physician(required):___________________________________

Insurance Carrier(required):____________________________________

Preferred Pharmacy:____

Is it ok to leave a message? Yes_______ No_______
If so which phone number is the best number to use?______________________

Please list your current medications:
Name:________________________ Dose:_____________________
Name:________________________ Dose:_____________________
Name:________________________ Dose:_____________________
Name:________________________ Dose:_____________________

What are your current symptoms:_______________________________________
____
____

Please list any allergies you may have:__________________________________
____

Do/Have you ever smoke(d)? Yes____No___If yes, how much & for how long?____

How much beer or alcoholic beverages do you drink daily?____________________

What is your current occupation?_______________________________________

Please list any serious illnesses or hospitalizations you have had in the past:
____
____
____

Please tell us about any neurological illnesses within your family:_______________
____
____

(For office use) BP__________ Pulse_________ Height _________ Weight_______

Review of Systems (Please check any symptoms that apply)

Constitutional Symptoms
___Appetite Change
___Fever
___Sleep Disturbance
___Weight Loss
___Weight Gain

Skin
___Easy Bruising
___Rash
___Tick Bite(this year)

Eyes
___Double Vision
___Dry Eyes
___Glaucoma
___Episode of Visual Loss

Ear/Nose/Mouth/Throat
___Decreased sense of smell or taste
___Hearing Loss
___Hoarseness or change in voice
___Swallowing difficulty

Respiratory
___Asthma/Wheezing
___Shortness of Breath

Cardiovascular
___Chest Pain or Angina
___Fainting
___Heart Failure
___High Cholesterol
___Hypertension
___Irregular Heartbeat(palpitations)

Genitourinary
___Kidney Stones
___Loss of Bladder Control

Bones & Joints
___Arthritis
___Swollen Joints

Psychiatric
___Depression
___Hallucinations
___Anxiety
___Panic Attacks

Endocrine
___Breast Discharge
___Diabetes
___Excessive/Decreased Sweating
___Thyroid Disease

Hematologic
___Anemia
___Bleeding Disorders
___History of Blood Clots
___Past Infusions(when?)________

Gastrointestinal
___Blood in Stool
___Constipation
___Diarrhea
___History of GI Bleeding
___Loss of Bowel Control
___Nausea or Vomiting
___Ulcer Disease

If you are here for headaches, please fill this section out as well.

1. When did the headaches start? ______________________________

2. On average, how many headaches do you experience per month? ____________

3. How long do they usually last? ______________________________

4. How do you describe the pain? Select all that apply
   - o Sharp
   - o Throbbing
   - o Dull
   - o Stabbing
   - o Other ______________________________

5. On a scale of 1 to 10, how bad is the pain? (10 being the worst) ____________

6. Have you experienced any of the following with your headaches? Select all that apply.
   - o Nausea
   - o Vomiting
   - o Sensitivity to light
   - o Sensitivity to sound
   - o Tearing from eyes
   - o Nose dripping
   - o None of these
   - o Other ______________________________

7. What medications (including over-the-counter medications and prescriptions) or treatments have you tried for your headaches and /or migraines? Please list the dose and the duration of each medication.

   ____
   ____
   ____
   ____
   ____
   ____

8. How many times a week do you have a headache that requires medication?

   ____

9. What makes your headache worse? ______________________________

10. What makes your headache better? ______________________________