



Neurology Questionnaire

3344 N. Futrall Drive
Fayetteville, AR 72703
479-582-7330



General

Name _____ DOB _____ Age _____

Referring Physician _____

What is the main problem? _____

_____ Right Handed/Left Handed/Both

When did it begin? _____ What caused it? _____

What brings it on? _____

What makes it better? _____

What makes it worse? _____

How long does it last? _____

Past Medical History

List any health problems (diabetes, heart disease, high blood pressure, cancer, etc.)

What hospitalizations have you had and when?

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____
4. _____ Date _____
5. _____ Date _____

Medications

What medicines are you taking, BOTH prescription and non-prescription?

1. _____ Dose _____ Times per day _____ How long _____
2. _____ Dose _____ Times per day _____ How long _____
3. _____ Dose _____ Times per day _____ How long _____
4. _____ Dose _____ Times per day _____ How long _____
5. _____ Dose _____ Times per day _____ How long _____

Are you allergic to any medications? _____

Have you suffered an accident _____ Date _____ MVA/Workers-Comp/Liability

Describe your accident _____

Your attorney's name _____ Phone _____

Are you in litigation or is it planned? _____

Personal and Family Information

Do you use tobacco? Current Smoker-Everyday (indicate how much) _____ Current Smoker-occasional _____

Former Smoker Never Smoked Smoker-current status unknown Unknown if ever smoked

Do you use alcohol _____ Type _____ How much per day _____ How long _____

Do you drink beverages with caffeine? _____ How much per day? _____

What is your most physically demanding activity that you do regularly? _____

_____ How often? _____

What is your occupation? _____

How long? _____ Your previous job _____

Marital Status _____

Do you live alone _____ with a spouse _____ with parents _____ with children _____ with friends _____

Family History

Please record any health problems such as high blood pressure, heart disease, diabetes, headaches, seizures, stroke, memory loss, etc. If deceased, age at death and cause

Father _____

Mother _____

Brothers and Sisters _____

Children _____

Health Review Please check any of these that you have recently had a problem with. If you do not check the symptom, then it is assumed it is not a problem for you.

General

- Fever
- Weight Loss
- Night Sweats

Eyes

- Eye Pain
- Glaucoma
- Blurred vision not corrected by glasses
- Cataracts

Ears, Nose, Throat

- Trouble hearing
- Ringing of ears
- Trouble breathing through nose
- Difficulty swallowing
- Hoarseness

Cardiovascular

- Chest pain
- Rapid heart beat
- Irregular heart beat
- Rheumatic fever
- Blood clots in legs
- Phlebitis
- Shortness of breath lying down

Pulmonary

- Cough
- Coughing up phlegm
- Coughing up blood
- Pneumonia
- Collapsed lung
- Tuberculosis
- Shortness of breath when walking
- Asthma

Cardiovascular

- Snoring
- Quit breathing in sleep
- Daytime drowsiness
- Restless legs
- Excessive leg movement
- Insomnia

Gastrointestinal

- Indigestion
- Heart burn
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Black stools
- Loss of appetite
- Ulcers
- Hiatal Hernia
- Jaundice
- Hepatitis
- Gall Stones
- Colitis of Enteritis
- Cirrhosis
- Pancreatitis
- Hemorrhoids

Genitourinary

- Urinary tract infections
- Burning with urination
- Dark or bloody urine
- Kidney stones
- Syphilis
- Gonorrhea
- HIV
- Other venereal diseases
- Trouble starting urination
- Bladder not emptying
- Decreased urinary stream

For Women

- Date of last menstrual period _____
- Type of birth control practiced _____
- Are you pregnant? _____
- Pain or other problems with intercourse? _____
- Decreased sex drive? _____

For Men

- Difficulty with erection? _____
- Prostate? _____
- Decreased sex drive? _____
- Discharge from penis? _____

Neurological

- Headache
- Neck pain
- Back pain
- Weakness
- Numbness
- Unsteadiness
- Dizziness
- Loss of coordination
- Tremor, shaking
- Confusion
- Memory loss
- Spells, Seizures
- Stroke
- Traumatic brain injury

Musculoskeletal

- Joint stiffness, pain
- Joint swelling
- Muscle pain

Skin, Breast

- Rash
- Non-healing sores
- Changes in moles
- Breast pain or lump
- Breast discharge

Psychiatric

- Depression
- Anxiety
- Crying spells
- Hallucinations

Endocrine

- Change in menses
- Heat intolerance
- Cold intolerance
- Lactation

Hematologic/Lymphatic

- Anemia
- Fatigue
- Swollen Glands

Allergic/Immunologic

- Hayfever
- Frequent infections
- AID's

Signature _____

Date _____