FAYETTEVILLE DIAGNOSTIC CLINIC a mana clinic

Neurology Questionnaire

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 _____

Martial 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 "Yes" for any symptoms that apply to you. If the symptom is not marked as Yes, it indicates it is not a problem for you. Please ask the nurse if you are uncertain.

Yes	No	General
□	□	Fever
□	□	Weight Loss
□	□	Night Sweats

Yes	No	Eyes
□	□	Eye Pain
□	□	Glaucoma
□	□	Blurred vision not corrected by glasses
□	□	Cataracts

Yes	No	Ears, Nose, Throat
□	□	Trouble Hearing
□	□	Ringing of ears
□	□	Trouble breathing through nose
□	□	Difficulty swallowing
□	□	Hoarseness

Yes	No	Cardiovascular
□	□	Chest pain
□	□	Rapid heart beat
□	□	Irregular heart beat
□	□	Rheumatic fever
□	□	Blood clots in legs
□	□	Phlebitis
□	□	Shortness of breath lying down

Yes	No	Pulmonary
□	□	Cough
□	□	Coughing up phlegm
□	□	Coughing up blood
□	□	Pneumonia
□	□	Collapsed lung
□	□	Tuberculosis
□	□	Shortness of breath when walking
□	□	Asthma

Yes	No	Cardiovascular
□	□	Snoring
□	□	Quit breathing in sleep
□	□	Daytime drowsiness
□	□	Restless legs
□	□	Excessive leg movement
□	□	Insomnia

Yes	No	Gastrointestinal
□	□	Indigestion
□	□	Heart burn
□	□	Nausea
□	□	Vomiting
□	□	Diarrhea
□	□	Constipation
□	□	Black stools
□	□	Loss of appetite
□	□	Ulcers
□	□	Hiatal Hernia
□	□	Jaundice
□	□	Hepatitis
□	□	Gall Stones
□	□	Colitis or enteritis
□	□	Cirrhosis
□	□	Pancreatitis
□	□	Hemorrhoids

Yes	No	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?

_____

For Men

Difficulty with erection?

Prostate?

Decreased sex drive?

Discharge from penis?

Yes	No	Neurological
□	□	Headache
□	□	Neck pain
□	□	Back pain
□	□	Weakness
□	□	Numbness
□	□	Unsteadiness
□	□	Dizziness
□	□	Loss of coordination
□	□	Tremor, shaking
□	□	Confusion
□	□	Memory Loss
□	□	Spells, Seizures
□	□	Stroke
□	□	Traumatic brain injury

Yes	No	Musculoskeletal
□	□	Joint stiffness, pain
□	□	Joint swelling
□	□	Muscle pain

Yes	No	Skin, Breast
□	□	Rash
□	□	Non-healing sores
□	□	Changes in moles
□	□	Breast pain or lump
□	□	Breast discharge

Yes	No	Psychiatric
□	□	Depression
□	□	Anxiety
□	□	Crying spells
□	□	Hallucinations

Yes	No	Endocrine
□	□	Change in menses
□	□	Heat intolerance
□	□	Cold intolerance
□	□	Lactation

Yes	No	Hematologic/Lymphatic
□	□	Anemia
□	□	Fatigue
□	□	Swollen glands

Yes	No	Allergic/Immunologic
□	□	Hayfever
□	□	Frequent infections
□	□	AIDS

_____ _____

Signature Date

APPOINTMENT CANCELLATION POLICY

MANA Neurology requires a 24-hour notice of cancellation of appointments. Please note there will be a **$50.00 fee** charged to the patient if the appointment is not cancelled 24-hours prior.

I have read and understand this policy.

PRINT NAME: _____ D.O.B.: _____

PATIENT SIGNATURE: _____ DATE: _____

HOME PHONE #_____ CELL PHONE # _____

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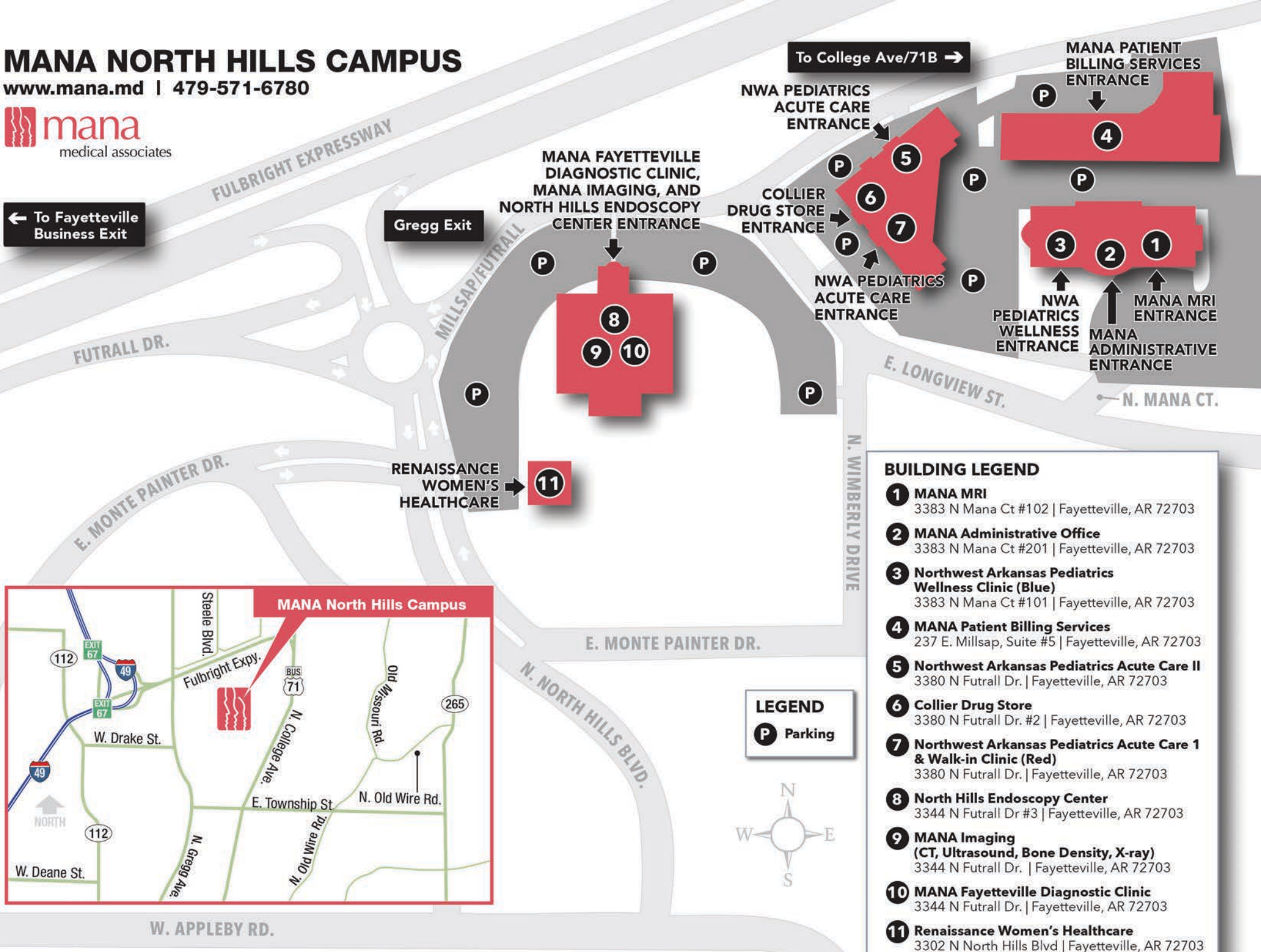

LEGEND

P Parking

BUILDING LEGEND

1. **MANA MRI**
   3383 N Mana Ct #102 | Fayetteville, AR 72703
2. **MANA Administrative Office**
   3383 N Mana Ct #201 | Fayetteville, AR 72703
3. **Northwest Arkansas Pediatrics Wellness Clinic (Blue)**
   3383 N Mana Ct #101 | Fayetteville, AR 72703
4. **MANA Patient Billing Services**
   237 E. Millsap, Suite #5 | Fayetteville, AR 72703
5. **Northwest Arkansas Pediatrics Acute Care II**
   3380 N Futrall Dr. | Fayetteville, AR 72703
6. **Collier Drug Store**
   3380 N Futrall Dr. #2 | Fayetteville, AR 72703
7. **Northwest Arkansas Pediatrics Acute Care 1 & Walk-in Clinic (Red)**
   3380 N Futrall Dr. | Fayetteville, AR 72703
8. **North Hills Endoscopy Center**
   3344 N Futrall Dr #3 | Fayetteville, AR 72703
9. **MANA Imaging (CT, Ultrasound, Bone Density, X-ray)**
   3344 N Futrall Dr. | Fayetteville, AR 72703
10. **MANA Fayetteville Diagnostic Clinic**
    3344 N Futrall Dr. | Fayetteville, AR 72703
11. **Renaissance Women's Healthcare**
    3302 N North Hills Blvd | Fayetteville, AR 72703