Physicians' Clinic of Iowa, P.C.

NEUROLOGY QUESTIONNAIRE

Return to Dr. ____________________

Date ____________ Time ____________

Date of first appointment ____________ First Name ____________ Last Name ____________

Date of Birth ____________ Age ______ Birthplace ____________

Gender: ☐ Male ☐ Female 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)*

☐ Headaches ____________ ☐ Chronic Pain Syndrome ____________ ☐ Depression ____________

☐ Seizures ____________ ☐ Atrial Fibrillation/Flutter ____________ ☐ Drug or Alcohol Addiction ____________

☐ Back or Joint Problems ____________ ☐ Anxiety ____________

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?

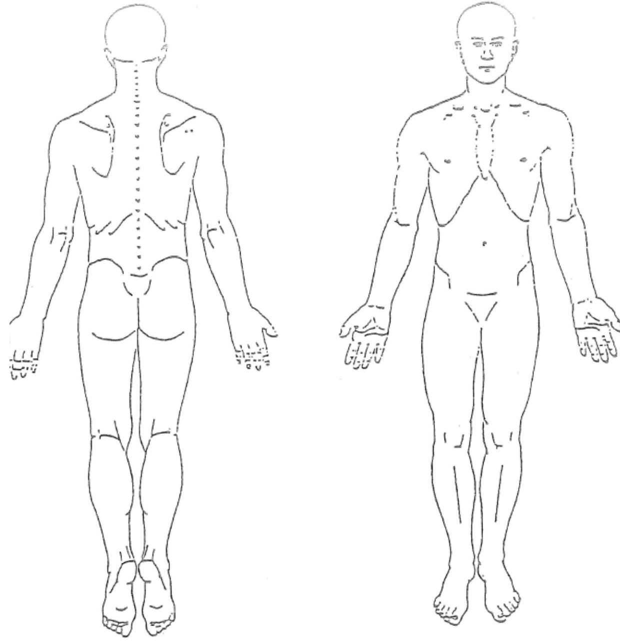
    ☐ Yes ☐ No Does it go way if you move your feet or get up and walk?

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 ☐ Standing ☐ Walking ☐ Lying Down ☐ Putting on Shoes ☐ Light
☐ Bending ☐ Driving ☐ Coughing ☐ Straining ☐ Riding in a Car ☐ Sound

Other: ______________________

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

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Recent Weight Gain
- ☐ Recent Weight Loss

Endocrine
- ☐ Excessive Thirst
- ☐ Heat Intolerance
- ☐ Cold Intolerance

Skin
- ☐ Skin Rash
- ☐ Skin Lump

Eyes
- ☐ Blurry Vision
- ☐ Seeing Double

Ear/Nose/Throat
- ☐ Sore Throat
- ☐ Nasal Congestion

Cardiovascular
- ☐ Chest Pain or Discomfort
- ☐ Palpitations
- ☐ Leg Swelling

Respiratory
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Frequent Cough

Hematological
- ☐ Swollen Glands in Neck
- ☐ Easy Bleeding - Recurrent

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn

Musculoskeletal
- ☐ Joint Pain
- ☐ Neck Pain
- ☐ Back Pain

Psychological
- ☐ Depression
- ☐ Anxiety

Genitourinary
- ☐ Urinary Loss of Control
- ☐ Urinary Frequency at Night
- ☐ Painful urination

Neurological
- ☐ Neurological Symptoms:

____

____

Patient Signature: ______________________ Date: ______________

Provider Signature: ______________________ Date: ______________