Your name: ____________________________

Circle: **Right** or **Left** Handed ?

Appointment Date:____/ ____/ _________

Your Birthdate:_______________**AGE:**_________

Your Doctor:_______________________________

Dr.'s Phone Number:____________________

PLEASE TELL US YOUR STORY- 1ST VISIT

(We want to get to know you)

What is your MAIN reason for seeing a neurologist today?

Describe your MAIN problem. (EXAMPLE: headache is pounding on the left side of my head and making me sick)

When did this problem begin? (EXAMPLE. Childhood. Last week last month.)

Do you have any other nerve or muscle-related problems that are currently bothering you? (EXAMPLE: lower back pain tingling in my feet and hands)

PAIN ASSESSMENT Are you in pain today? NO___, YES,___ if yes where How severe use scale below to indicate Make a mark on the below pain scale (if you are in pain right now) the represents your pain right now.

1= No pain and 10= the most severe pain ever

1________________________5__________________________10

List all medications currently taking or in the past.

C = Current take daily S = Sometimes take, if needed (PRN) P = PAST Took in the past not currently

C S P 1:______________________
C S P 2:______________________
C S P 3:______________________
C S P 4:______________________
C S P 5:______________________
C S P 6:______________________
C S P 7:______________________
C S P 8:______________________
C S P 9:______________________
C S P 10:______________________

HOSPITALIZATIONS and MEDICAL ILLNESSES.

Have you ever stayed as a patient in a hospital over night? **Yes No**

If yes, how many times?_________ For what conditions? ______________________________

Circle any illnesses that you have: *Diabetes? High Blood Pressure? Heart Problems? Gastric distress? Liver problems? Kidney Problems? Past strokes? Blood clots? Others?*__________________

HEADACHE QUESTIONS

Do you have any headaches? **Yes No** If *yes,* at what age did you get *your first memorable headache?* ___ If yes:

How many days per month are you *completely headachefree?* (Circle below)

1-5 days? 6-10 days? 11-15? 15-20 days? More than 20 days per month without any headaches?

Are any of your headaches pounding or throbbing? **Yes No** Nausea? **Yes No** Light or sound sensitive? **Yes No**

What is the longest a headache has lasted? *Half day Entire day More than one day Just a few minutes?*

Does your headache begin in a particular place in your head? *Front left side right side back of head around eyes?*

Do your headaches occur most often in: Morning, Afternoons, Evenings, Awaken you from sleep? **Yes No**

Have you ever gone to the Emergency Room for headaches? **Yes No**

What do you take or do to make your headaches go away? ______________________________

Head Injury? (Dates, description)____

SLEEP QUESTIONS

Do you feel that you sleep well?____ What time do you turn off the lights?______ Is the TV on? **Yes No**

Generally, how long does it take you to fall asleep? (Circle one)

5 Minutes or less 10-15 Minutes 15-30 Minutes 30-60 Minutes 60 Minutes or more

Do you sometimes take medicines to fall asleep? **Yes No** If yes, what medicines:_________

Do you have dreams?____ Nightmares?_____ Sleep walk or talk?________Do you use CPAP/BiPAP?________

Do you snore? (or does bed partner say you snore?) **Yes No** Do you kick or jump around? **Yes No**

Do you grind your teeth or clench your jaw?______

How many times do you awaken at night?_____ What wakes you up?____________Pets? Spouse snoring?

Do you awaken to an alarm clock? **Yes No** Are you sleepy during the days? **Usually No Sometimes**

Do you feel well rested and alert in the morning upon awakening? **Yes No**

What time is lights on?_________ .....What time do you actually get out of bed?___________

Do you drink Coffee, Tea, or Power Drinks in the morning to wake up? **Yes No**

Do you sometimes take a nap during the day? **Yes sometimes. Never**

EPWORTH SLEEPNESS SCALE

Over the **past month**, how likely are you to doze off or fall asleep in the following situations

(0= not a chance 1= possible, 2= likely, 3= high likelihood or have done so)

0 1 2 3 While sitting and reading?
0 1 2 3 While watching TV?
0 1 2 3 Sitting inactive in a public place, (Example: movies or meeting)
0 1 2 3 As a passenger in a car driving for an hour or so without a break?
0 1 2 3 Lying down in the afternoon nap permitted?
0 1 2 3 While sitting and talking to people?
0 1 2 3 While sitting quietly after lunch without alcohol?
0 1 2 3 While stopped in a car for a few moments at a stop light?

TOTAL SCORE (sum of all numbers) ____________

FAMILY

Mother: Alive or Deceased (circle one) If Alive, What is current age?_____ Health?_______
If Deceased, What age, and From what condition?__________________________
Father: Alive or Deceased (circle one) If Alive, what is current age?______Health?__________
If Deceased, what age, and from what condition?__________________________
Brothers, How many? _______ What ages_________ Sisters, How many? _______ What ages_________
What number child are you? ______ Youngest Sibling? (Sister Brother, Alive or deceased age?)__________
Does anyone in your family have an illness similar to what brings you in today? If yes, explain
Are you married (or have you been married?) **Yes** **No**
Do you have children? **Yes** **No** If yes, how many and what ages? __________________________

SOCIAL QUESTIONS

Do you use tobacco? **Yes** **No** If yes, what type and how often (EXAMPLE "I smoke a pipe 5 times a day")
How long have you been using tobacco?___________________
Do you use any recreational drugs? (circle) Weed? Cocaine? Ice? Meth? Others:________________
Do you consume alcohol on a daily bases? **Yes** **No** If yes, what types of drinks and how much ?
(EXAMPLE, Mixed drinks, vodka, about 5 or 6 a day or, two beers per night ______________________
When do you have your 1st alcoholic drink? Morning___ Mid-day___ Afternoon ___ Night____ Pauhana______
Do drink alcohol only with friends, or at parties, and not on a daily basis? **Yes** **No**
Do you exercise? **Yes** **No** **Sometimes** How often and for how long?__________________________
Have you ever had an alien encounter? **Yes** **No** if yes, when? __________________________

MEDICINE ALLERGIES:

List all Medicine allergies and what happens when you take the medicine (Example, makes me itch, hives, etc.)

If none, circle: *No medicine Allergies*

PAST MEDICAL HISTORY, SYSTEMS and SYMPTOMS REVIEW

DO YOU HAVE or HAVE HAD ANY OF THE FOLLOWING for MORE THEN A MONTH?

Generalized pain that will not go away:
Fever:
Chills:
Night sweats
Weight loss or gain:
Nasal discharge:
Lumps in neck or body
Heart beat problems:
Chest pain:
Pounding heart:
Cancer:
Diabetes:
Anemia:
Arthritis:
Thyroid:
High or low blood pressure:
Vaccinations:
Neck pain:
Back pain:
Headaches:
Stroke:
Seizures:
Heart Disease:
Polio:
Snoring:
Shortness of breath while walking:
Shortness of breath while climbing stairs:
Pain when you breath deeply:
Cough that will not go away:
Trouble eating or swallowing:
Constant heartburn:
Pain upon eating or swallowing:
Constipation chronically:
Genitourinary symptoms:
Denied frequent urges:
Painful or excessive urination:
Sexual difficulties impotence :
Unable to function:

DO YOU EVER FEEL LIKE HURTING YOUR SELF

IF YES-do you feel that way right now ___________________
IF YES- who do, or have you wanted to hurt ______________________
Explain:
In General, how would you describe yourself? Circle one
HAPPY SERIOUS ANGRY SLEEPY SAD

OFFICE USE ONLY

Blood Pressure:

Pulse:

Resp:

Weight:

Height:

BMI:

Vision

Left: 20/

Right: 20/

Both: 20/

Med Allergies:

Comments: