

**Your name:** \_\_\_\_\_

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

**Appointment Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Your Birthdate:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

**Your Doctor:** \_\_\_\_\_

**Dr.'s Phone Number:** \_\_\_\_\_

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**PLEASE TELL US YOUR STORY- 1<sup>ST</sup> VISIT**

*{ We want to get to know you - email to ADMIN@HawaiiPacificDEEG or bring to 1st appointment}*

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	6:	_____
C S P	2:	_____	C S P	7:	_____
C S P	3:	_____	C S P	8:	_____
C S P	4:	_____	C S P	9:	_____
C S P	5:	_____	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 headache free?* (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 1<sup>st</sup> 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: