SWEDISH NEUROSCIENCE SPECIALISTS
Initial visit patient questionnaire

Please fill out before your appointment and bring with you to your appointment, along with any prior medical records or films.

Date: _____

Name: _____ **SSN or MRN:** _____

DOB: _____ **Age:** _____ **Sex:** ☐ Male ☐ Female **Dominant Hand:** ☐ Right ☐ Left

Referring provider: _____

Referring provider's address: _____

Primary care provider: _____

Primary care provider's address: _____

Reason for this visit: _____

_____

PAST MEDICAL HISTORY	**PAST SURGICAL HISTORY**

MEDICATIONS/dosing schedule: (including all nonprescription/over-the-counter medications and supplements)

Pill	**Dose**	**Times**

MEDICATIONS tried in the PAST for the condition for which you are currently being seen. Please list highest dose used, as well as reason for stopping.

Medication	Highest dose used	Reason for stopping

ALLERGIES: ☐ No ☐ Yes (if yes, please list below):

Allergic to/Reaction

SOCIAL HISTORY:

☐ Married ☐ Partnered ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Occupation (past occupation if retired): _____

Highest level of education: _____

City & State of birth: _____ First language: _____

Who do you live with (circle below if applicable) _____

Caregiver Group Home Assisted Living Nursing Home

Use of assisted devices: Cane Walker Wheelchair Other assisted device _____

Use of Tobacco: ☐ Never ☐ Quit in _____ (year) ☐ Currently, for ____ years, _____ pack(s) per day
Use of Alcohol: ☐ Never If yes, how many glasses per day, week, or month _____
Recreational Drugs: ☐ Never ☐ Currently, for ____ years, _____ (type & frequency)

FAMILY HISTORY:

Does anyone in your family have a history of neurological conditions, such as Parkinson's disease or seizures? ☐ Yes ☐ No

Please list below all medical problems in your family and age at death if applicable:

REVIEW OF SYSTEMS: *Do you currently have any of the following problems?*

	No	Yes	(if yes, please circle or list)
Constitutional: fever, chills, sweats, weight loss, weight gain, fatigue	☐	☐	_____
Head: blurry vision, loss of vision, double vision, eye pain, facial numbness hearing loss, ringing in ears, vertigo/spinning, trouble swallowing/talking, sinus problems	☐	☐	_____
Cardiac: chest pain, palpitations, irregular heart beat, dizziness, fainting	☐	☐	_____
Respiratory: shortness of breath, coughing/wheezing	☐	☐	_____
Gastrointestinal: nausea/vomiting, abdominal pain, constipation/diarrhea, incontinence	☐	☐	_____
Genitourinary: urinary frequency/urgency/incontinence, trouble starting stream, impotence, loss of interest in sex, inability to become aroused/reach orgasm	☐	☐	_____
Musculoskeletal: joint pain, cramps	☐	☐	_____
Dermatologic: rash, itching	☐	☐	_____
Hematologic/Immunologic: bruising, clotting difficulties, anemia	☐	☐	_____
Psychiatric: depression, anxiety, hallucinations	☐	☐	_____
Endocrine: thyroid disease, diabetes, menstrual problems	☐	☐	_____

	No	Yes	(if yes, please circle or list)
Neurologic: seizures/loss of consciousness, headaches, loss of smell, numbness/tingling, pain, tremor/shaking, poor balance/falls, trouble walking, poor hand coordination/difficulty writing, speech difficulty, word-finding difficulty, memory problems, sleep difficulties	☐	☐	_____ _____

Have you ever had:

☐ Head injury ☐ Meningitis ☐ Stroke ☐ Seizures (including childhood or febrile seizures)

☐ Previous exposure to psychiatric meds, including Haldol, Risperdal, etc.

☐ Previous exposure to antinausea meds including Reglan, Compazine