PACIFIC ADULT HYDROCEPHALUS CENTER

AT PACIFIC NEUROSCIENCE INSTITUTE℠

PATIENT QUESTIONNAIRE

Name: _____ Date: _____

Your phone numbers: *Home:* _____ *Cell:* _____ E-Mail address: _____

Emergency Contact Person: _____ Phone number: _____

I came to see Dr. Barkhoudarian by:

- ☐ Referral from another physician (name): _____
- ☐ Referral from a friend or another patient (name): _____
- ☐ My own research (explain): _____

Prior to seeing Dr. Barkhoudarian, I went online to review the Pacific Adult Hydrocephalus Center website ☐ Yes ☐ No

Which doctors need a copy of today's consultation note from Dr. Barkhoudarian? Please provide phone and fax numbers.

1. _____ 3. _____
2. _____ 4. _____

Do you have memory difficulties? ☐ Yes ☐ No When did this start? _____

Do you have any difficulties with ambulation? ☐ Yes ☐ No When did this start? _____

Any Falls? ☐ Yes ☐ No If so, how often? _____

Do you have any urinary incontinence? ☐ Yes ☐ No When did this start? _____

Have you undergone a lumber puncture or drain trial? _____

Have you been diagnosed with other medical problems?

- ☐ High blood pressure _____
- ☐ Heart disease (heart attack) _____
- ☐ High cholesterol/ Hyperlipidemia _____
- ☐ Diabetes _____
- ☐ Lung disease/ Asthma _____
- ☐ Thyroid _____
- ☐ Gastro-intestinal problems _____
- ☐ Kidney Disease/ dialysis _____
- ☐ Depression _____
- ☐ Alzheimer's/Parkinson's disease _____
- ☐ Seizures _____
- ☐ Stroke _____
- ☐ Other _____

Please list any operations and the year performed (If you have a VP shunt, indicate value type and last setting)

1. _____
2. _____
3. _____

MEDICATIONS

Are you taking any medications? Yes ☐ No ☐ If **YES** please list below:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

ALLERGIES: Do you have any allergies to medications? Yes ☐ No ☐ If **YES** please list below

1. _____ 3. _____
2. _____ 4. _____

2125 Arizona Ave, Santa Monica, CA 90404
Phone 310-582-7450 | Fax 310-582-7495 | www.pacifichydrocephalus.org

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SOCIAL HISTORY

☐ Married ☐ Single ☐ Children? Number _____

Are you currently employed? Yes ☐ No ☐ Current occupation _____

Are you disabled? _____ If YES, how long? _____

Do you drink alcohol? _____ If YES, how often? _____ Do you smoke? If YES, how often? _____

FAMILY HEALTH HISTORY

Has anyone in your immediate family (siblings, parents, children) experienced any of the following conditions? Indicate their relationship to you in the space next to the box:

☐ Heart disease (heart attack) _____

☐ Lung disease/ Asthma _____

☐ Diabetes _____

☐ Depression _____

☐ Seizures _____

☐ Cancer – type? _____

☐ High blood pressure _____

☐ Kidney Disease/ dialysis _____

☐ Thyroid problem _____

☐ Alzheimer's/Parkinson's disease _____

☐ Stroke _____

☐ Other issues _____

REVIEW OF SYSTEMS: Please indicate any of the following symptoms you are experiencing:

General

Y	N	Don't Know	
☐	☐	☐	Fever, chills, sweats
☐	☐	☐	Loss of appetite, weight loss

Eyes

Y	N	Don't Know	
☐	☐	☐	Eyes irritation/infection
☐	☐	☐	Glaucoma/cataract/eye surgery
☐	☐	☐	Wear glasses/contacts

ENT/Mouth

Y	N	Don't Know	
☐	☐	☐	Earache/ringing
☐	☐	☐	Sinusitis, runny nose, allergies
☐	☐	☐	Oral ulcerations

Respiratory

Y	N	Don't Know	
☐	☐	☐	Asthma, emphysema/bronchitis
☐	☐	☐	Cough
☐	☐	☐	Recent chest x-ray
☐	☐	☐	Tuberculosis

Cardiovascular

Y	N	Don't Know	
☐	☐	☐	Short of breath
☐	☐	☐	Irregular heartbeat

Psychiatric

Y	N	Don't Know	
☐	☐	☐	Depression
☐	☐	☐	Anxiety disorder

Gastrointestinal

Y	N	Don't Know	
☐	☐	☐	Nausea/vomiting
☐	☐	☐	Diarrhea/constipation/bloody stools
☐	☐	☐	Heartburn/indigestion/reflux disease
☐	☐	☐	Polyps/colonoscopy

Genitourinary

Y	N	Don't Know	
☐	☐	☐	Increased urination
☐	☐	☐	Diarrhea/constipation/bloody stools

Musculoskeletal

Y	N	Don't Know	
☐	☐	☐	Leg cramps
☐	☐	☐	Arthritis/arthralgias/gout
☐	☐	☐	Soft tissue/bony trauma
☐	☐	☐	Congenital deformity

Skin

Y	N	Don't Know	
☐	☐	☐	Leg ulcers/discoloration of feet/legs
☐	☐	☐	Bruising/bleeding tendencies
☐	☐	☐	Acne

Reproductive

Y	N	Don't Know	
☐	☐	☐	Normal periods
☐	☐	☐	Absent periods
☐	☐	☐	Irregular periods
☐	☐	☐	Post-menopausal
☐	☐	☐	Pre-menopausal
☐	☐	☐	Hysterectomy

Please sign below:

Patient Signature: _____

Affix Patient Label Here

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