PACIFIC MOVEMENT DISORDERS CENTER

AT PACIFIC NEUROSCIENCE INSTITUTE®

NEW PATIENT QUESTIONNAIRE

Last Name **First Name** **DOB**

What is your reason for the visit?

How did you hear about the Pacific Movement Disorders Center? Check all that apply.

☐ Referring doctor's name _____

☐ Website ☐ Mailer ☐ Newsletter ☐ Friend / another patient ☐ Other: _____

Are you: ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

Prior Medical Issues or Diagnoses: (or you may attach a list)

☐ Parkinson's
☐ Tremor
☐ High blood pressure (Hypertension)
☐ Diabetes (including high blood sugar)
☐ Heart disease
☐ Cancer
☐ Traumatic brain injury or concussion
☐ Stroke
☐ Ataxia (gait disorder)
☐ Seizures or epilepsy
☐ Headaches
☐ Lung disease
☐ Liver disease
☐ Kidney disease
☐ Depression or anxiety
☐ Dystonia
☐ Other:

Prior Surgeries:

Medication List including doses:

You may attach a list. Please include all supplements, over the counter meds and vitamins.

Allergies or Intolerances:

Social History:

Are you: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

What do you do for work? If retired, what did you do for work?

Tobacco use (including chewing tobacco):

☐ Never ☐ Prior (Approx. quit date _____) ☐ Current Maximum packs per day _____

Caffeine use: ☐ Never ☐ Prior ☐ Occasional ☐ Frequent Ave. # of drinks per week _____

Alcohol use: ☐ Never ☐ Prior ☐ Occasional ☐ Frequent Ave. # of drinks per week _____

Drug use: ☐ Never ☐ Prior ☐ Current Type and frequency _____

NEW PATIENT QUESTIONNAIRE /CONTINUED

Family History (Do not include your own medical history):
Do you have any blood relatives who have the following:

☐ Parkinson's disease ☐ Seizures or epilepsy ☐ Blood clots
☐ Tremor ☐ Gait disorder (imbalance) ☐ Brain tumor
☐ Dystonia ☐ Dementia or memory loss ☐ Nerve or muscle disease
☐ Stroke ☐ Headache ☐ Twitches or jerks

☐ Other: _____

Review of systems:
Please mark off if you have experienced any of these symptoms in the past couple weeks:

General: ☐ weight loss ☐ weight gain ☐ fevers ☐ night sweats ☐ fatigue ☐ loss of appetite
Eyes: ☐ blurry vision ☐ double vision ☐ bright lights, flashing lights, spots or dots in vision
☐ sensitivity to light ☐ glaucoma ☐ wavy lines, zigzag lines, swirly lines, kaleidoscope
Ears, nose, mouth, throat: ☐ hearing loss ☐ muffled hearing ☐ ringing in ears ☐ dizziness (vertigo)
☐ trouble swallowing ☐ sinus pressure ☐ nasal discharge ☐ ear pain
☐ Change in sense of smell or taste
Cardiovascular: ☐ shortness of breath ☐ chest pain or pressure ☐ palpitations (feeling of heart racing)
☐ passing out spells ☐ swelling in legs ☐ low blood pressure ☐ high blood pressure
☐ lightheadedness upon standing
Pulmonary: ☐ cough ☐ wheezing ☐ coughing up blood
Gastrointestinal: ☐ nausea ☐ vomiting ☐ diarrhea ☐ constipation ☐ stool incontinence
Genitourinary: ☐ frequent urination ☐ urgency ☐ incontinence ☐ trouble getting urine out
☐ erectile dysfunction ☐ low libido
Neurological: ☐ headache ☐ memory loss ☐ loss of consciousness ☐ numbness or tingling
☐ weakness ☐ muscle cramps ☐ tremor ☐ lack of coordination
☐ falls ☐ falls resulting in injury ☐ slowness of walking or movement
☐ shuffling gait ☐ stooped posture ☐ reduced armswing ☐ dragging feet
☐ muscle stiffness ☐ twitching or jerking ☐ slurred speech ☐ change in voice
Psychological: ☐ depression ☐ anxiety ☐ personality change ☐ auditory hallucinations
☐ paranoia ☐ agitation ☐ visual hallucinations ☐ suicidal thoughts
Sleep: ☐ trouble falling asleep ☐ trouble staying asleep ☐ snoring
☐ irregular breathing during sleep ☐ kicking or punching during dreams
☐ vivid dreams or nightmares ☐ restless legs ☐ sleeping too much during the day
Endocrine: ☐ cold intolerance ☐ heat intolerance ☐ enlarged size of hands or fingers
☐ change in size of facial features ☐ history of kidney stones
For women: ☐ irregular periods ☐ menopause
Skin / breast: ☐ stretch marks ☐ leaking from breasts ☐ rash
Musculoskeletal: ☐ joint pain ☐ joint swelling ☐ muscle pain ☐ reduced range of motion
Hematologic: ☐ bleeding ☐ bruising ☐ use of blood thinners
Allergic/Immunologic: ☐ environmental allergies ☐ swollen lymph nodes ☐ lumps or swelling

Please verify the above is correct. Patient / caregiver signature _____

Questions you would like to address during today's visit:

1. _____

2. _____

Are you open to receiving information about potential clinical trials and community events? Please include your email address _____