PACIFIC NEUROSCIENCE INSTITUTE℠

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BRAIN HEALTH CLINIC QUESTIONNAIRE

PATIENT INFORMATION

Native Language:	
Referring Physician's Full Name:	Telephone #:
Physician's Address:	
Are you: ☐ Right Handed ☐ Left-handed ☐ Ambidextrous	
Why do you need to see a Neurology specialist?	
Past Medical History:	Date of Diagnosis:
Hospitalizations / Operations:	Date(s):
Injuries – Include any episodes of loss of consciousness:	Date(s):
Blood Transfusions:	Date(s):
Drug Allergies	Reactions:

For office use: This questionnaire may be completed by the patient, relative or ancillary staff provided that it is signed and dated by the treating physician. (Reference may later be made to this information by a signed and dated statement by the treating physician, designating location of the information, date obtained and any subsequent charges.)

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Medications

Name	Dosage	How Often?

(Write on back or attach additional sheet if necessary)

Dietary Supplements / Vitamins:

Name	Dose and Frequency (how often?)

Social History

Any use of tobacco (type and for how long)? _____

Any use of caffeinated beverages? _____

Any use of alcohol (type and for how long)? _____

Any use of recreational drugs (type and for how long)? _____

Any exposure to toxins/poisonous substances at work or with hobbies? _____

What type of work do you do? _____

Education: ☐ Grade School ☐High School ☐College ☐Post-Graduate ☐Voc. Training

Marital Status: ☐Single ☐Married ☐Divorced ☐ Separated ☐Widowed

Birthplace: _____

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Family History

Mother: ☐ Living or ☐ Deceased? Age: _____
Health Problems: _____

Father: ☐ Living or ☐ Deceased? Age: _____
Health Problems: _____

Brothers/Sisters: List from oldest to youngest.

1. Brother or Sister? ☐ Living or ☐ Deceased? Age: _____
Health Problems: _____

2. Brother or Sister? ☐ Living or ☐ Deceased? Age: _____
Health Problems: _____

3. Brother or Sister? ☐ Living or ☐ Deceased? Age: _____
Health Problems: _____

4. Brother or Sister? ☐ Living or ☐ Deceased? Age: _____
Health Problems: _____

Children: List from oldest to youngest.

1. Daughter or Son? ☐ Living or ☐ Deceased? Age: _____
Health Problems: _____

2. Daughter or Son? ☐ Living or ☐ Deceased? Age: _____
Health Problems: _____

3. Daughter or Son? ☐ Living or ☐ Deceased? Age: _____
Health Problems: _____

Has any of your family or relative members had any of the following conditions? If yes, whom?

Heart Disease	_____	Stroke	_____
High Blood Pressure	_____	Fainting	_____
High cholesterol	_____	Diabetes	_____
Loss of Memory	_____	Cancer	_____
Epilepsy/seizures	_____	Multiple sclerosis	_____
Depression	_____	Polio	_____
Mental disease	_____	Limping	_____
Muscle weakness	_____	Thyroid disease	_____

Other: _____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.
BE SURE TO BRING IT TO YOUR DOCTOR'S APPOINTMENT.

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REVIEW OF SYSTEMS

Please place a checkmark if you currently have any of the following symptoms.

1. Constitutional	☐ fever	☐weight loss	☐fatigue
2. Eye problems	☐blurred vision	☐double vision	☐loss of vision
	☐eye pain	☐eye redness	☐eye dryness
3. Ear/Nose/Throat	☐trouble hearing	☐ringing in ear(s)	☐dizziness (vertigo)
	☐loss of balance	☐ear pain	☐ear discharge
	☐hoarseness	☐trouble swallowing	☐slurred speech
4. Cardiovascular	☐chest pain	☐irregular heart	☐fast heart beat
	☐limb swelling	☐limb pain on walking	☐fainting
5. Respiratory	☐trouble breathing	☐chronic cough	☐coughing blood
6. Gastrointestinal	☐indigestion	☐heart burn	☐abdominal pain
	☐nausea	☐vomiting	☐regurgitation
	☐diarrhea	☐constipation	☐bloody stools
7. Genitourinary	☐incontinence	☐pain on urination	☐blood in urine
8. Musculoskeletal	☐muscle pain	☐muscle cramps	☐muscle twitches
	☐loss of muscle bulk	☐neck pain	☐back pain
	☐joint pain	☐joint stiffness	☐joint swelling
9. Skin & breast	☐numbness	☐tingling	☐discoloration
10. Neurologic	☐headache	☐face pain	☐face numbness
	☐weakness	☐tremors	☐clumsiness
	☐blackouts	☐trouble	☐trouble concentrating
11. Psychiatric	☐hallucinations	☐feeling depressed	☐trouble sleeping
	☐suicidal thoughts	☐inappropriate crying	☐inappropriate laughing
12. Hematological/Lymphatic	☐abnormal bleeding	☐nose bleeds	☐lumps or swellings
13. Allergic/immunologic	☐skin rash	☐joint pain	☐dry eyes
14. Endocrine	☐excessive thirst	☐heat or cold Intolerance	☐excessive urination

Patient or Representative Signature _____ Date _____
If signed by someone other than the patient, please specify relationship to patient: _____
Interpreter Signature _____ ID# _____ Date _____
Physician Signature _____ ID# _____ Date _____

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