## PATIENT QUESTIONNAIRE

Name: 

Your phone numbers:  
Home:  
Cell:  
Emergency Contact Person:  

E-Mail address:  

Phone number:  

Date:  

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.  
2.  
3.  
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 lumbar puncture or drain trial?  

Have you been diagnosed with other medical problems?  

- High blood pressure  
- High cholesterol/ Hyperlipidemia  
- Lung disease/ Asthma  
- Gastro-intestinal problems  
- Depression  
- Seizures  
- Other  

- Heart disease (heart attack)  
- Diabetes  
- Thyroid  
- Kidney Disease/ dialysis  
- Alzheimer’s/Parkinson’s disease  
- Stroke  

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

**ALLERGIES:**  
Do you have any allergies to medications?  

- Yes  
- No  
If YES please list below:  

1.  
2.  
3.  
4.
PACIFIC ADULT HYDROCEPHALUS CENTER
AT PACIFIC NEUROSCIENCE INSTITUTE℠

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) __________________________         ☐ High blood pressure __________________________
☐ Lung disease/ Asthma __________________________           ☐ Kidney Disease/ dialysis __________________________
☐ Diabetes __________________________                     ☐ Thyroid problem __________________________
☐ Depression __________________________                   ☐ Alzheimer’s/Parkinson’s disease __________________________
☐ Seizures __________________________                     ☐ Stroke __________________________
☐ Cancer – type? __________________________              ☐ 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