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

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, swirlly 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
- [ ] sensitivity to light
- [ ] glaucoma
- [ ] wavy lines, zigzag lines, swirlly lines, kaleidoscope

**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
- [ ] frequent urination
- [ ] urgency
- [ ] incontinence
- [ ] trouble getting urine out
- [ ] erectile dysfunction
- [ ] low libido

**Genitourinary:**
- [ ] 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 arm swing
- [ ] dragging feet
- [ ] muscle stiffness
- [ ] twitching or jerking
- [ ] slurred speech
- [ ] change in voice

**Neurological:**
- [ ] depression
- [ ] anxiety
- [ ] personality change
- [ ] auditory hallucinations
- [ ] paranoia
- [ ] agitation
- [ ] visual hallucinations
- [ ] suicidal thoughts
- [ ] headache
- [ ] memory loss
- [ ] loss of consciousness
- [ ] numbness or tingling

**Psychological:**
- [ ] depression
- [ ] anxiety
- [ ] personality change
- [ ] auditory hallucinations

**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
- [ ] 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. ______________________________________
3. ______________________________________