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 ________________

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

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 ________________

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

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

- [ ] Parkinson’s disease
- [ ] Tremor
- [ ] Dystonia
- [ ] Stroke
- [ ] 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, swirling lines, kaleidoscope

Ears, nose, mouth, throat:  
- [ ] hearing loss
- [ ] muffled hearing
- [ ] ringing in ears
- [ ] dizziness (vertigo)
- [ ] Change in sense of smell or taste

Cardiovascular:  
- [ ] shortness of breath
- [ ] chest pain or pressure
- [ ] palpitations (feeling of heart racing)
- [ ] passing out spells
- [ ] 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

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 arm swing
- [ ] 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
- [ ] history of kidney stones
- [ ] change in size of facial features

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 ____________________________