

PACIFIC BRAIN TUMOR CENTER

AT PACIFIC NEUROSCIENCE INSTITUTESM

PATIENT QUESTIONNAIRE

Name: _____ Date: _____

Your phone numbers: Home: _____ Cell: _____ E-Mail address: _____

Emergency Contact Person: _____ Phone number: _____

I came to see Dr. Kelly/ Barkhoudarian by: _____ Referral from another physician (name): _____

_____ Referral from a friend or another patient (name): _____

_____ My own research (explain): _____

_____ Other: _____

Prior to seeing Dr. Kelly/ Barkhoudarian I went online and reviewed the BTC Website ___ Yes ___ No

Why are you seeing Dr. Kelly/ Barkhoudarian? _____

What are your symptoms related to this problem?

1. _____

3. _____

2. _____

4. _____

Have you been diagnosed with other medical problems?

High blood pressure _____

Heart disease (heart attack) _____

High cholesterol/ Hyperlipidemia _____

Diabetes _____

Lung disease/ Asthma _____

Thyroid _____

Gastro-intestinal problems _____

Kidney Disease/ dialysis _____

Depression _____

Alzheimer's/Parkinson's disease _____

Seizures _____

Stroke _____

Pituitary/Hormone disorders _____

Brain tumor (benign or malignant) _____

Cancer – type? _____

Other issues _____

Please list any past surgeries and the year performed:

1. _____

2. _____

3. _____

Which doctors need a copy of today's consultation note from Dr. Kelly/ Barkhoudarian? Please provide phone and fax numbers.

1. _____ 3. _____

2. _____ 4. _____

MEDICATIONS

Are you taking any medications? Yes No If **YES** please list below:

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

ALLERGIES: Do you have any allergies to medications? Yes No If **YES** please list below and describe reaction to medication:

1. _____ 3. _____

2. _____ 4. _____

Clinic address: 2121 Santa Monica Boulevard, Santa Monica, CA 90404

Mailing address & Administrative offices: 2020 Santa Monica Blvd CA 90404

Phone 310-582-7450 | Fax 310-582-7495 | www.pacificbraintumor.org

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SOCIAL HISTORY

Married Single Children? Number: _____

Are you currently employed? Yes No Current position? _____

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:

- | | |
|---|--|
| <input type="checkbox"/> Heart disease (heart attack) _____ | <input type="checkbox"/> High blood pressure _____ |
| <input type="checkbox"/> Lung disease/ Asthma _____ | <input type="checkbox"/> Kidney Disease/ dialysis _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Thyroid problem _____ |
| <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Alzheimer's/Parkinson's disease _____ |
| <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Cancer – type? _____ | <input type="checkbox"/> 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

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