UCLA NEUROTOLOGY PATIENT QUESTIONNAIRE

Please complete questionnaire and bring it with you to your appointment.

Patient's name: _____ Today's date: _____

Age: _____ Date of birth: _____ Sex: female _____ male _____

Are you right handed, left handed or ambidextrous? _____

If not English-speaking, native language: _____

Referred by: _____

Why do you need to see a neurology specialist? _____

_____

PAST MEDICAL HISTORY

Drug Allergies (for example, penicillin, novocaine, iodine): _____

_____

Medications (current): _____

_____

(recent): _____

Surgeries (with dates): _____

_____

_____

Injuries, with dates (especially fractures, loss of consciousness): _____

_____

Blood transfusions? (with dates): _____

SOCIAL HISTORY

Use of tobacco (type and duration): _____

Use of alcohol (type and duration): _____

Exposure to toxins (work, hobbies): _____

Occupation: _____

Education: _____

Marital status: _____

Birthplace: _____

FAMILY HISTORY

Circle the appropriate word.

Mother: living or deceased? Age _____ Specific health conditions _____

Father: living or deceased? Age _____ Specific health conditions _____

Brothers and/or sisters: *List from oldest to youngest. Circle the appropriate word.*

1. brother or sister? living or deceased? Age _____ Specific health conditions _____
2. brother or sister? Living or deceased? Age _____ Specific health conditions _____

3 brother or sister? Living or deceased? Age _____Specific health conditions _____

4. brother or sister? Living or deceased? Age _____Specific health conditions _____

5. brother or sister? Living or deceased? Age _____Specific health conditions _____

6. brother or sister? Living or deceased? Age _____Specific health conditions _____

7. brother or sister? Living or deceased? Age _____Specific health conditions _____

8. brother or sister? Living or deceased? Age _____Specific health conditions _____

Children: *List from oldest to youngest. Circle the appropriate word.*

1. daughter or son? Living or deceased? Age _____Specific health conditions _____

2. daughter or son? Living or deceased? Age _____Specific health conditions _____

3. daughter or son? Living or deceased? Age _____Specific health conditions _____

4. daughter or son? Living or deceased? Age _____Specific health conditions _____

Have any of the following conditions occurred in other members of your family? If so, in whom?

heart disease _____stroke _____

high blood pressure _____ faints_____

high cholesterol _____ diabetes _____

memory loss _____ cancer _____

epilepsy or seizures _____ MS _____

depression/psychosis _____ polio _____

muscle weakness _____ migraine _____

thyroid disease _____ dizziness _____

ataxia _____ other_____

REVIEW OF SYSTEMS

Please place a check mark in front of any of the following items which you are experiencing at present.

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 beat	_____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 cramp	_____muscle twitches
	_____loss of muscle bulk	_____neck pain	_____back pain
	_____joint pain	_____joint stiffness	_____joint swelling

9. **skin**:	_____numbness	_____tingling	_____discoloration
	_____hair loss	_____nail changes	_____sweating changes
10. **neurologic**:	_____headache	_____face pain	_____face numbness
	_____weakness	_____tremors	_____clumsiness
	_____blackouts	_____trouble with memory	_____trouble concentrating
11. **psychiatric**:	_____hallucinations	_____feeling depressed	_____trouble sleeping
	_____suicidal thoughts	_____inappropriate crying	_____inappropriate laughing
12. **hematologic/lymphatic**:	_____abnormal bleeding	_____nose bleeds	_____lumps or swellings
13. **allergic/immunologic**:	_____skin rash	_____joint pain	_____dry eyes &/or dry mouth
14. **endocrine**:	_____excessive thirst	_____heat or cold intolerance	_____excessive urination

DIZZINESS/IMBALANCE

A. Do you have any of the following symptoms? Please circle Yes or No and circle ear involved if appropriate.

Yes No 1. Dizziness. Describe: _____

Yes No 2. Difficulty in hearing Both ears Right Left

When did you first notice hearing loss? _____

Yes No Does hearing change with dizziness? If so, how? _____

Yes No 3. Noise in your ears Both ears Right Left

When did you first notice the noise? _____

Describe the noise: _____

Yes No Does noise change with dizziness? If so, how? _____

Yes No 4. Fullness or stuffiness in your ears Both ears Right Left

B. If you have dizziness. please answer all of the following questions. Circle Yes or No and fill in the blank spaces.

1. When did dizziness first occur? _____
2. How often do you become dizzy? _____
3. If in attacks, how long does an attack last? _____

When was last attack? _____

Yes No Do you have any warning that the attack is about to occur?

Yes No Do attacks occur at any particular time of day or night?

Yes No Are you completely free of dizziness between attacks?

Yes No 4. Does change of position make you dizzy?

Yes No 5. Do you know of any possible cause of your dizziness? What? _____

_____

6. Do you know of anything that will:

Yes No Stop your dizziness or make it better? _____

_____

Yes No Make your dizziness worse? _____

_____

7 . Can any of the following make your dizziness worse or precipitate an attack?

Yes No Fatigue

Yes No Exertion

Yes No Hunger

Yes No Menstrual period

Yes No Stress

Yes No Emotional upset

Yes No Alcohol

C. Is your dizziness associated with any of the following sensations? Please read the entire list first. Then circle Yes or No to describe your feelings most accurately.

Yes No 1. Lightheadedness or "swimming" sensation in the head

Yes No 2. Blacking out or loss of consciousness

Yes No 3. Tendency to fall

Yes No 4. Objects spinning or turning around you

Yes No 5. Sensation that you are turning or spinning inside, with outside objects remaining stationary

Yes No 6. Loss of balance when walking: Veering to the right? _____ Left? _____

Yes No 7. Headache

Yes No 8. Nausea or vomiting

Yes No 9. Pressure in the head

D. Have you experienced any of the following symptoms? Please circle Yes or No and circle if constant or in episodes.

Yes	No	1. Double vision, blurred vision, or blindness	Constant	In episodes
Yes	No	2. Numbness of face or extremities	Constant	In episodes
Yes	No	3. Weakness in arms or legs	Constant	In episodes
Yes	No	4. Clumsiness in arms or legs	Constant	In episodes
Yes	No	5. Confusion or loss of consciousness	Constant	In episodes
Yes	No	6. Difficulty with speech	Constant	In episodes
Yes	No	7. Difficulty with swallowing	Constant	In episodes
Yes	No	8. Pain in neck or shoulder	Constant	In episodes

Person completing these forms: _____ *Relationship to patient:* _____

The above information--Past Medical History, Family History, Social History and Review of Systems-- may be obtained as a questionnaire completed by the patient, relatives 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 changes

Signature of physician: _____ *Date:* _____