

# NEUROSCIENCE INSTITUTE & BRAIN TUMOR CENTER

## PATIENT QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Your phone numbers: Home \_\_\_\_\_ Cell: \_\_\_\_\_ E-Mail address: \_\_\_\_\_

Emergency contact person: \_\_\_\_\_ Phone number: \_\_\_\_\_

Why are you seeing Dr. Kelly or Dr. Kassam? \_\_\_\_\_

What are your symptoms related to this problem?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Have you been diagnosed with other medical problems?

- |   |  |
|---|--|
| <input type="checkbox"/> High blood pressure _____              | <input type="checkbox"/> Heart disease (Heart attack): _____   |
| <input type="checkbox"/> High Cholesterol/ Hyperlipidemia _____ | <input type="checkbox"/> Diabetes _____                        |
| <input type="checkbox"/> Lung disease/Asthma _____              | <input type="checkbox"/> Thyroid problems _____                |
| <input type="checkbox"/> Gastro-intestinal problems _____       | <input type="checkbox"/> Kidney disease/Dialysis _____         |
| <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: _____                   |

Please list any past surgeries and the year performed:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Which doctors are you currently seeing and which doctors need a copy of today's consultation note?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

### MEDICATIONS

Are you taking any medications? Y  N  If YES please list below:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

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

If YES please list below and describe your reaction to the medication:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

### SOCIAL HISTORY

Please fill out information below:

Married  Single  Children? Number: \_\_\_\_\_ Handedness? Right Left Ambidextrous

Are you currently employed? \_\_\_\_\_ Current position? \_\_\_\_\_

Are you disabled? \_\_\_\_\_ How long? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ If yes, how often? \_\_\_\_\_ Do you smoke? \_\_\_\_\_ If yes, how often? \_\_\_\_\_

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## **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 problems _____               |
| <input type="checkbox"/> Depression _____                   | <input type="checkbox"/> Alzheimers/Parkinson's disease _____ |
| <input type="checkbox"/> Seizures _____                     | <input type="checkbox"/> Stroke _____                         |
| <input type="checkbox"/> Cancer – type? _____               | <input type="checkbox"/> Other issue: _____                   |

## **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**

- Eye irritation/ infection  
   Glaucoma/ cataract/ eye surgery  
   Wear glasses/ contacts  
   Difficulty urinating, blood in urine

### **ENT/ Mouth**

- Earache/ ringing  
   Sinusitis, runny nose, allergies  
   Oral ulcerations

### **Respiratory**

- Asthma, emphysema/bronchitis  
   Cough  
   Recent chest x-ray  
   Tuberculosis

### **Cardiovascular**

- Short of breath  
   Irregular heart beat

### **Psychiatric**

- Depression  
   Anxiety disorder

### **Gastrointestinal**

Y    N    Don't  
Know

- Nausea/ vomiting  
   Diarrhea/ constipation/ bloody stools  
   Heartburn/ indigestion/reflux disease  
   Polyps/colonoscopy

### **Genitourinary**

- Increased urination

### **Musculoskeletal**

- Leg cramps  
   Arthritis/ arthralgias/ gout  
   Soft tissue/ bony trauma  
   Congenital deformity

### **Skin**

- Leg ulcers/ discoloration of feet/legs  
   Bruising/ bleeding tendencies  
   Acne

### **Reproductive**

- Normal periods  
   Absent periods  
   Irregular periods  
   Post-menopausal  
   Pre-menopausal  
   Hysterectomy  
   Taking birth control

**Please sign below:**

Patient Signature: \_\_\_\_\_

**Affix Patient Label Here**