Lexington Clinic
Since 1920

Name _____
Age _____

Dr. Patrick Leung
Neurology Department
Patient Questionnaire

Home # _____
Work # _____
Email _____

Date: _____

My main symptom or problem (the reason I am here) is: _____
_____

Please tell us the name and address of the physician who sent you to see us.

_____
(Physician Name) (City) (State)

Who is your primary care physician? _____

CURRENT MEDICATIONS: Please list below all drugs or medicines taken over the last week (include birth control pills, eye drops, aspirin, any medicine bought without a prescription.)

Name of drug or medicine	Dose if known	How many daily?	Name of drug or medicine	Dose if known	How many daily?
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Please list any drug **allergies** below:

1.	3.
2.	4.

(Please answer the questions on the other side)

PAST MEDICAL HISTORY:
Please check here if you have been told by a doctor that you have any of the listed conditions.

Condition	✓	Condition	✓	Condition	✓
Heart disease		Alzheimer's		Parkinson's disease	
High blood pressure		Anxiety		Stroke	
High cholesterol		Depression		Arthritis	
Cancer		Neurologic condition		Glaucoma	
Diabetes		Migraine headaches		TB	
Other:		Other:		Other:	

PAST SURGICAL HISTORY:

Surgery Type	Date	Surgeon/Hospital
1.		
2.		
3.		

FAMILY HISTORY: Please check (✓) if any family member(s) have had this condition and indicate which member by using the following key in the column marked FM:

F = father M=mother S = sister B=brother GF = grandfather GM=grandmother

Condition	✓	FM	Condition	✓	FM	Condition	✓	FM
Alcoholism			Diabetes			Mental Illness/Suicide		
Alzheimer's Disease			Epilepsy/Seizures			Parkinson's Disease		
Cancer			Heart Disease			Stroke		
Dementia			High Blood Pressure			Other Neurological Disease		

IMMUNIZATION HISTORY:

Immunization	Date	Provider/Location
Influenza Immunization		
Pneumococcal Vaccination		

SOCIAL HISTORY

Do you smoke cigarettes? YES _____ NO _____ QUIT _____ # of packs per day _____
Do you drink alcohol? YES _____ NO _____
Are you: Single _____ Married _____ Divorced _____ Widowed _____
Do you live alone or with family?_____
Your occupation? _____ Highest school grade you attended? _____

REVIEW OF SYSTEMS: Please circle YES or NO

Eyes:		Urination with cough	YES NO	Irritable	YES NO
Eye - pain	YES NO	Urination with sneeze	YES NO	Loss of interest in activities	YES NO
Eye - dryness	YES NO	Sexual difficulty	YES NO	Loss of interest in people	YES NO
Blurry vision	YES NO	**Musculo/Skeletal:**		Nervous	YES NO
Double vision	YES NO	Joints – swollen	YES NO	Personality change	YES NO
Vision loss	YES NO	Muscle cramps	YES NO	Sad	YES NO
Ear, Nose, Throat:		Muscle soreness	YES NO	Suicidal thoughts	YES NO
Ear – ringing	YES NO	Muscle stiffness	YES NO	Withdrawn	YES NO
Ear – pain	YES NO	Muscle twitching	YES NO	**Endocrine:**	
Dry mouth	YES NO	Pain – arm	YES NO	Always cold	YES NO
Hearing Loss	YES NO	Pain – back	YES NO	Always hot	YES NO
Sore throat	YES NO	Pain – leg	YES NO	Frequently thirsty	YES NO
Heart:		Pain – limb	YES NO	**Hematological:**	
Chest pain	YES NO	Pain – neck	YES NO	Bleed easily	YES NO
Heart racing	YES NO	**Skin:**		Bruise easily	YES NO
Heartbeat pounding	YES NO	Abnormal sweating	YES NO	Glands swollen	YES NO
Pulmonary:		Skin – blisters	YES NO	**Allergy:**	
Cough	YES NO	Skin – dry	YES NO	Eye – burning	YES NO
Cough blood	YES NO	Skin – itching	YES NO	Nose – runny	YES NO
Cough phlegm	YES NO	Skin – peeling	YES NO	Chemical sensitivity	YES NO
Wheezing	YES NO	Skin – rash	YES NO	**Constitutional:**	
Short of Breath	YES NO	**Neurological:**		Fatigue	YES NO
Digestive System:		Dizziness	YES NO	Fever	YES NO
Difficulty swallowing	YES NO	Forgetfulness	YES NO	Loss of appetite	YES NO
Constipation	YES NO	Headaches	YES NO	Night sweats	YES NO
Diarrhea	YES NO	Imbalance	YES NO	Shaking chills	YES NO
Heartburn	YES NO	Jerking	YES NO	Poor sleep	YES NO
Nausea	YES NO	Lightheadedness	YES NO	Daytime sleepiness	YES NO
Pain - stomach	YES NO	Shaking	YES NO	Snoring	YES NO
Stools – black	YES NO	Numbness	YES NO	Weight loss	YES NO
Stools – bright red blood	YES NO	Slurred speech	YES NO		
Vomiting	YES NO	Tremor	YES NO		
Genitourinary:		Tingling	YES NO		
Blood in urine	YES NO	Weakness	YES NO		
Difficulty emptying bladder	YES NO	Uncoordinated	YES NO		
Incontinence	YES NO	**Psychological:**			
Urination – burning	YES NO	Angry	YES NO		
Urination – dribbling	YES NO	Crying spells	YES NO		
Urination – frequent	YES NO	Depressed	YES NO		

_____ _____
Patient Signature Date Physician Signature Date