Office Use	Doctor:	LRDC Chart #:	Appointment Date:
only			

Little Rock Diagnostic Clinic Neurology - Patient Questionnaire

This information will become part of the medical record and is subject to federal privacy laws.

Full Nam	ne:			Date of	Birth:	
E-mail a	ddress:			Cell Pho	one:	
Describe	the medical	problem or r	eason that you are	here for evalu	ation today.	
	Circle all th	at apply: t	obacco use, high	ı blood pressu	re, diabetes, h	eart disease
When did	l it start?					
How long	does it last	?				
Where is	it located? _					
How seve	ere is it?					
How ofte	n does it occ	cur?				
Aggravat	ed by?					
Relieved	by?					
Vitals		This box will	l be completed by Pleas	/ the nursing e DO NOT w		der's office
Ht	WT	Temp	ВР	Pulse	Resp	Pulse ox

Please list the medications you are currently taking. Please include all over-the-counter and herbal medications (use back of page if needed):

Medication Name	Dosage	How often	Started	Problem medication for	Doctor who wrote

Pharmacy Name and Address	
Do you get your medications for 30 days or 90 days at a time? (circle one)	

Please list any drug allergies or side effects (use back page if needed)

When	Drug	Describe Reaction

Immunizations (list date of last)

Tetanus	Pneumonia	Shingles	Flu	

List all the physicians that you are currently seeing:

Physician Name	Specialty	Condition Physician is treating	Next Office Visit

Review of Systems- MEN ONLY

Please check a box below for every question that applies to your current health

General	No	Yes	Urinary	No	Yes	Skin	No	Yes
Chills			Dribbling			Brittle hair		
Fatigue			Painful urination			Brittle nails		
Fever			Blood in urine			Hair loss		
Night sweats			Excessive urination			Excessive hair growth		
Tired			Slow stream			Hives		
Weight gain			Increased frequency			Itching		
Weight loss			Unable to hold urine			Mole changes		
Other:			Trouble emptying bladder			Rash		
Other.			Other:			Skin lesion		
			Other.			Skiii lesion		
Head/Neck	No	Yes	Reproductive	No	Yes	Other:		
Ear drainage			Erection problems					
Ear pain			Discharge from penis			Musculoskeletal	No	Yes
Eye discharge			Decreased libido			Back pain		
Eye pain			other	<u> </u>		Joint pain		
Hearing loss			ouie.			Joint swelling		
Nasal drainage			Metabolic	No	Yes	Muscle weakness		
Sinus pressure			Cold intolerance		T	Neck pain		
Sore throat			Heat intolerance			Other:		
Visual changes			Always thirsty			Other.		
Other:			Always hungry			Blood/lymph	No	Yes
Other.			Other:			Easy bleeding	INO	163
Dosnirator.	No	Yes	Other.			,		
Respiratory	INO	res	Navadarias	N.	Vaa	Easy bruising		
Chronic cough			Neurological	No	Yes	Enlarged lymph nodes		
Recent cough			Dizziness		+	Other:		
Known TB exposure			Numbness in arms/legs					.,
Shortness of breath			Weakness in arms/legs			Immunity	No	Yes
Wheezing			Trouble walking			Contact allergy		
Other:			Headache			Environmental allergy		
			Memory loss			Food allergy		
Heart	No	Yes	Seizures			Seasonal allergy		
Chest pains			Tremors			Other:		
Leg pain with walking			Other:					
Swelling in legs								
Heart racing			Psychiatric	No	Yes			
Other:			Anxiety					
			Depression					
Gastrointestinal	No	Yes	Trouble sleeping					
Abdominal pain			Other:					
Blood in stools								
Change in stools								
Constipation								
Diarrhea								
Heartburn								
Loss of appetite								
Nausea								
Vomiting								
Other:								

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Review of Systems- WOMEN ONLY

Please check a box below for every question that applies to your current health

General	No	Yes	Urinary	No	Yes	Psychiatric	No	Yes
Chills			Painful urination			Anxiety		
Fatigue			Blood in urine			Depression		
Fever			Excessive urination			Trouble sleeping		
Night sweats			Increased frequency			Other:		
Tired			Unable to hold urine					
Weight gain			Trouble emptying bladder			Metabolic	No	Yes
Weight loss			Other:			Cold intolerance		
Other:	-		•		,	Heat intolerance		
						Always thirsty		
Head/Neck	No	Yes	Reproductive	No	Yes	Always hungry		
Ear drainage			Abnormal pap smear			Other:		
Ear pain			Painful periods					
Eye discharge			Painful intercourse			Musculoskeletal	No	Yes
Eye pain			Hot flashes			Back pain		
Hearing loss			Irregular periods			Joint pain		1
Nasal drainage			Vaginal discharge			Joint swelling		1
Sinus pressure			Other:			Muscle weakness		1
Sore throat						Neck pain		+
Visual changes			Skin	No	Yes	Other:	L	
Other:		I	Breast discharge			2 3.12.1		
•			Breast lump			Blood/lymph	No	Yes
Respiratory	No	Yes	Brittle hair			Easy bleeding		T
Chronic cough		103	Brittle nails			Easy bruising		-
Recent cough			Hair loss			Enlarged lymph nodes		-
Known TB exposure			Excessive hair growth			Other:		
Shortness of breath			Hives			Other.		
Wheezing			Itching			Immunity	No	Yes
Other:			Mole changes			Contact allergy	INO	1 63
Other.			Rash			Environmental allergy		-
Heart	No	Yes	Skin lesion			Food allergy		-
	INO	163	Other:			-		-
Chest pains			Other:			Seasonal allergy Other:	<u></u>	
Leg pain with walking Swelling in legs			Neurological	No	Voc	Other.		
			Neurological Dizziness	No	Yes			
Heart racing			Numbness in arms/legs					
Other:								
Gastrointestinal	N.a	V	Weakness in arms/legs					
	No	Yes	Trouble walking					
Abdominal pain			Headache					
Blood in stools			Memory loss					
Change in stools			Seizures		+			
Constipation			Tremors	_				
Diarrhea			Other:					
Heartburn								
Loss of appetite								
Nausea								
Vomiting								
Other:								

Neurology Past Medical History

Place check all that apply to you

ADD/ADHD Alzheimer's Disease Angina Angina Arthritis Ansthma Blood Disease Cancer (type) Cardiac arrythmia Carpal tunnel/peripheral Congestive heart failure Cerebral infarction COPD Coronary artery disease Depression Alzheimer's Disease Elevated lipids Elevated lipids Blood Disease Fibromyalgia Fibromyalgia Peripheral nerve disease Seizure disorder Spinal disease, cervical Spinal disease, cervical Spinal disease, lumbar STI Stroke Thyroid disease Thyroid disease Other:		Diaperes		
Angina				
Arthritis	Alzheimer's Disease	Elevated lipids	Osteoporosis	
Asthma Blood Disease Cancer (type) Headache, migraine Cardiac arrythmia Hearing Disorder Spinal cord injury Carpal tunnel/peripheral Hearing problems Spinal disease, cervical Hepatitis/Liver disease Spinal disease, lumbar Cerebral infarction COPD Intracranial tumor Coronary artery disease Depression Mumps Mumps	Angina	Epilepsy	Parkinson's disease	
Blood Disease Cancer (type) Headache, migraine Seizure disorder Seizure disorder Spinal cord injury Spinal disease, cervical Carpal tunnel/peripheral Hearing problems Spinal disease, cervical Spinal disease, cervical Hepatitis/Liver disease Spinal disease, lumbar Spinal disease, lumbar Spinal disease, lumbar Spinal disease, lumbar Stroke Coronary artery disease Mental disorder Mental disorder Thyroid disease Depression Mumps	Arthritis	Fibromyalgia	Peripheral nerve disease	
Cancer (type) Cardiac arrythmia Carpal tunnel/peripheral Congestive heart failure Cerebral infarction COPD Coronary artery disease Depression Headache, tension Hearing Disorder Hearing Disorder Spinal cord injury Spinal disease, cervical Spinal disease, lumbar Stroke Mental disorder Mental disorder Mumps Seizure disorder Spinal cord injury Spinal disease, cervical Spinal disease, lumbar Stroke Thyroid disease Thyroid disease	Asthma	Head Injury	Polio	
Cardiac arrythmia Carpal tunnel/peripheral Congestive heart failure Cerebral infarction COPD Coronary artery disease Depression Hearing Disorder Spinal cord injury Spinal disease, cervical Spinal disease, lumbar STI Stroke Thyroid disease Thyroid disease	Blood Disease	Headache, migraine	Renal disease	
Carpal tunnel/peripheral Hearing problems Spinal disease, cervical Spinal disease, cervical Spinal disease, lumbar Hepatitis/Liver disease Hepatitis/Liver disease Spinal disease, lumbar STI Stroke Coronary artery disease Depression Mumps Mumps	Cancer (type)	Headache, tension	Seizure disorder	
Congestive heart failure Cerebral infarction COPD Coronary artery disease Depression Hepatitis/Liver disease Hypertension Hypertension Hypertension Hypertension Hypertension Hypertension Mumps Spinal disease, lumbar STI Stroke Mental disorder Mumps Mumps	Cardiac arrythmia	Hearing Disorder	Spinal cord injury	
Cerebral infarction Hypertension STI COPD Intracranial tumor Stroke Depression Mumps	Carpal tunnel/peripheral	Hearing problems	Spinal disease, cervical	
COPD Intracranial tumor Stroke Depression Mumps	Congestive heart failure	Hepatitis/Liver disease	Spinal disease, lumbar	
Coronary artery disease Depression Mental disorder Mumps Thyroid disease	Cerebral infarction	Hypertension	STI	
Depression Mumps	COPD	Intracranial tumor	Stroke	
	Coronary artery disease	Mental disorder	Thyroid disease	
Other:	Depression	Mumps		<u> </u>
	Other:			

Past Surgical History

Place the Year (if known) to all that apply to you

	Year		Year		Year	Gender Specific	Year
Heart Balloon		Colostomy		Small bowl resection		C-section	
Arthodesis		Craniectomy		Spinal bone allograph		D and C	
Arthroscopy		Gastric bypass		Thyroidectomy		Hysterectomy	
Back Surgery		Hernia repair				Mastectomy	
CABG		Hip replacement				Myomectomy	
Cardiac pacemaker		Knee replacement				Hysterectomy	
Carpal Tunnel		LASIK				Breast reduction	
Cataract Removal		Liver biopsy				TAH/BSO	
Colectomy		ORIF				Vaginal Hyst	
						Prostate biopsy	
						TURP	
						Vasectomy	
Additional:							

Family History

Place a check mark in the box to all that apply

__ Adopted/unknown

Adopted/unknown	Mother	Father	Sister	Brother	Other
Alive (age)					
Deceased (at what age)					
ADD/ADHD					
Alcoholism					
ALS					
Alzheimer's disease					
Asthma					
Cardiovascular disease					
Cancer					
Type of cancer					
CNS malignancy					
Congestive heart failure					
COPD					
Coronary artery diseasae					
Dementia					
Depression					
Developmental delay					
Diabetes					
Elevated lipids					
Epilepsy					
Genetic disease					
Headaches					
Hearing impairment					
Huntington's chorea					
Hypertension					
Inflammatory bowel disease					
Liver disease					
Multiple sclerosis					
Myocardial infarction					
Osteoporosis					
Peripheral nerve disease					
Peripheral vascular disease					
Renal disease					
Schizophrenia					
Seizure disorder					
Spinal disease, cervical					
Spinal disease, lumbar					
STI					
Stroke					
Thyroid disorder					
Tuberculosis					

Tuberculosis
Other family history:

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Social History

Tobacco History: Smoking Tobacco Use Non-Smoking Tobacco Use Tobacco Use Usage Age Tobacco Use Usage per Years Age Years Age Age started stopped Daily Type: daily per day used Type: day used started stopped ____ #packs/cig Cigarette Chewing units ____ cigarillos Cigarillo **Smokeless** ____ units cigars Cigar Snuff units Pipe ___ pipes Have you ever tried to quit smoking? No / Yes Year quit? _____ Cessation method? _____ Longest period tobacco free? _____ Relapsed? Yes / No If so, why? **Alcohol History:** Yes____ Formerly (list year quit) _____ No Type of alcohol _____ How frequently _____ How much a day? _____ When was your last drink? **Caffeine History:** Yes ____No ____ if Yes Type? _____ Servings Per Day_____ **Demographics:** The Federal Government requires us to collect the following information. This information is part of the medical record and is subject to privacy laws. Race (must choose one): American Indian or Alaskan Native Native Hawaiian or Other Pacific Islander ____White Asian Black or African American Other: Ethnicity (check one) ____Hispanic ____Non-Hispanic Primary Language Spoken:_____ Country of Birth (if not US): _____ Hand Dominance: ____Right ____Left ____Ambidextrous **Education:** Highest level of Education Any Degree obtained:_____ **Employment:** Employer: Occupation:_____ Employment Status: If Retired, Date: _____

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Military Experience:						
No Yes						
Branch						
Years served						
Domestic:						
Current Marital Status (ci	rcle one):	Single	Marrie	ed	Widowed	Divorced
Previously widowed? No		Yes	S			
Previously divorced? No			Yes	Yes		
Children? No			Yes	S	# Sons	# Daughters
Who lives with you?						
Sleep Patterns:						
Changes in sleep patterns:			No	Yes		
Average number of hours of s	leep per	night:				
Trouble falling asleep:			No	Yes		
Difficulty staying asleep:			No	Yes		
Frequent waking episodes at 1	night:		No	Yes		
Disrupted breathing, gasping,	gagging	or	No	Yes		
choking for air during sleep:						
Lifestyle:						
Activity level:ModerateSedentary			dentary	Vigorous		
· · · · · · · · · · · · · · · · · · ·			eviously	•		
Type of exercise:						
Exercise frequency:						
Hours/week:						
Hobbies/Activities:						
Current Diet :						
Animals in the home: No_ Ye	es	Type_				
Religious/Spiritual:						
Do you have a religious	s affiliatio	nn? No	Vac	Rali	gion name:	
Home Environment/Safety:	3 anniacio)II: NO _		Keli	gion name	
Smoke detectors ir	n home?	No	Yes			
Carbon monoxide detectors ir	n home?	No	Yes			
Falls in the last year? No Yes _			Yes	Numb	er of falls:	
Pool/spa at home: No Yes			Yes			
Seat b	elt use?	No	Yes			
Recent Travel						
Out of state? _				_		
l/						

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