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

Little Rock Diagnostic Clinic
Neurology - Patient Questionnaire

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

Full Name: _____ Date of Birth: _____

E-mail address: _____ Cell Phone: _____

Describe the medical problem or reason that you are here for evaluation today.

Circle all that apply: tobacco use, high blood pressure, diabetes, heart disease

_____

_____

_____

_____

_____

When did it start? _____

How long does it last? _____

Where is it located? _____

How severe is it? _____

How often does it occur? _____

Aggravated by? _____

Relieved by? _____

Vitals	This box will be completed by the nursing staff at the Provider's office Please DO NOT write.					
Ht	**WT**	**Temp**	**BP**	**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
Chills		
Fatigue		
Fever		
Night sweats		
Tired		
Weight gain		
Weight loss		
Other:		

Head/Neck	No	Yes
Ear drainage		
Ear pain		
Eye discharge		
Eye pain		
Hearing loss		
Nasal drainage		
Sinus pressure		
Sore throat		
Visual changes		
Other:		

Respiratory	No	Yes
Chronic cough		
Recent cough		
Known TB exposure		
Shortness of breath		
Wheezing		
Other:		

Heart	No	Yes
Chest pains		
Leg pain with walking		
Swelling in legs		
Heart racing		
Other:		

Gastrointestinal	No	Yes
Abdominal pain		
Blood in stools		
Change in stools		
Constipation		
Diarrhea		
Heartburn		
Loss of appetite		
Nausea		
Vomiting		
Other:		

Urinary	No	Yes
Dribbling		
Painful urination		
Blood in urine		
Excessive urination		
Slow stream		
Increased frequency		
Unable to hold urine		
Trouble emptying bladder		
Other:		

Reproductive	No	Yes
Erection problems		
Discharge from penis		
Decreased libido		
other		

Metabolic	No	Yes
Cold intolerance		
Heat intolerance		
Always thirsty		
Always hungry		
Other:		

Neurological	No	Yes
Dizziness		
Numbness in arms/legs		
Weakness in arms/legs		
Trouble walking		
Headache		
Memory loss		
Seizures		
Tremors		
Other:		

Psychiatric	No	Yes
Anxiety		
Depression		
Trouble sleeping		
Other:		

Skin	No	Yes
Brittle hair		
Brittle nails		
Hair loss		
Excessive hair growth		
Hives		
Itching		
Mole changes		
Rash		
Skin lesion		
Other:		

Musculoskeletal	No	Yes
Back pain		
Joint pain		
Joint swelling		
Muscle weakness		
Neck pain		
Other:		

Blood/lymph	No	Yes
Easy bleeding		
Easy bruising		
Enlarged lymph nodes		
Other:		

Immunity	No	Yes
Contact allergy		
Environmental allergy		
Food allergy		
Seasonal allergy		
Other:		

Review of Systems- WOMEN ONLY

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

General	No	Yes
Chills		
Fatigue		
Fever		
Night sweats		
Tired		
Weight gain		
Weight loss		
Other:		

Head/Neck	No	Yes
Ear drainage		
Ear pain		
Eye discharge		
Eye pain		
Hearing loss		
Nasal drainage		
Sinus pressure		
Sore throat		
Visual changes		
Other:		

Respiratory	No	Yes
Chronic cough		
Recent cough		
Known TB exposure		
Shortness of breath		
Wheezing		
Other:		

Heart	No	Yes
Chest pains		
Leg pain with walking		
Swelling in legs		
Heart racing		
Other:		

Gastrointestinal	No	Yes
Abdominal pain		
Blood in stools		
Change in stools		
Constipation		
Diarrhea		
Heartburn		
Loss of appetite		
Nausea		
Vomiting		
Other:		

Urinary	No	Yes
Painful urination		
Blood in urine		
Excessive urination		
Increased frequency		
Unable to hold urine		
Trouble emptying bladder		
Other:		

Reproductive	No	Yes
Abnormal pap smear		
Painful periods		
Painful intercourse		
Hot flashes		
Irregular periods		
Vaginal discharge		
Other:		

Skin	No	Yes
Breast discharge		
Breast lump		
Brittle hair		
Brittle nails		
Hair loss		
Excessive hair growth		
Hives		
Itching		
Mole changes		
Rash		
Skin lesion		
Other:		

Neurological	No	Yes
Dizziness		
Numbness in arms/legs		
Weakness in arms/legs		
Trouble walking		
Headache		
Memory loss		
Seizures		
Tremors		
Other:		

Psychiatric	No	Yes
Anxiety		
Depression		
Trouble sleeping		
Other:		

Metabolic	No	Yes
Cold intolerance		
Heat intolerance		
Always thirsty		
Always hungry		
Other:		

Musculoskeletal	No	Yes
Back pain		
Joint pain		
Joint swelling		
Muscle weakness		
Neck pain		
Other:		

Blood/lymph	No	Yes
Easy bleeding		
Easy bruising		
Enlarged lymph nodes		
Other:		

Immunity	No	Yes
Contact allergy		
Environmental allergy		
Food allergy		
Seasonal allergy		
Other:		

Neurology Past Medical History

Place check all that apply to you

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

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

	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					

Other family history:

_____

_____

_____

Social History

Tobacco History:

Smoking Tobacco Use

Tobacco Type:	Use daily	Usage per day	Years used	Age started	Age stopped
☐ Cigarette	☐	____ #packs/cig			
☐ Cigarillo	☐	____ cigarillos			
☐ Cigar	☐	____ cigars			
☐ Pipe	☐	____ pipes			

Non-Smoking Tobacco Use

Tobacco Type:	Use Daily	Usage per day	Years used	Age started	Age stopped
☐ Chewing	☐	____ units			
☐ Smokeless	☐	____ units			
☐ Snuff	☐	____ units			

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:

No____ Yes____ Formerly (list year quit) _____
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
____Asian
____Black or African American
____Native Hawaiian or Other Pacific Islander
____White
____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: _____

Military Experience:

No ___ Yes____
Branch _____
Years served _____

Domestic:

Current Marital Status (circle one): Single Married Widowed Divorced

Previously widowed? ___ No ___ Yes
Previously divorced? ___ No ___ Yes
Children? ___ No ___ Yes # Sons____ # Daughters ____
Who lives with you? _____

Sleep Patterns:

Changes in sleep patterns: ___ No ___ Yes
Average number of hours of sleep per night: _____
Trouble falling asleep: ___ No ___ Yes
Difficulty staying asleep: ___ No ___ Yes
Frequent waking episodes at night: ___ No ___ Yes
Disrupted breathing, gasping, gagging or choking for air during sleep: ___ No ___ Yes

Lifestyle:

Activity level: ___Moderate ___Sedentary ___Vigorous
Health club member: ___Now ___Previously ___Never
Type of exercise: _____
Exercise frequency: _____
Hours/week: _____
Hobbies/Activities: _____
Current Diet : _____
Animals in the home: No__ Yes __ Type_____

Religious/Spiritual:

Do you have a religious affiliation? No ___ Yes ___ Religion name: _____

Home Environment/Safety:

Smoke detectors in home? No ___ Yes ___
Carbon monoxide detectors in home? No ___ Yes ___
Falls in the last year? No ___ Yes ___ Number of falls: ___
Pool/spa at home: No ___ Yes ___
Seat belt use? No ___ Yes ___

Recent Travel

Out of state? _____
Out of country? _____
Known exposure to disease? _____