

Appointment Date: \_\_\_\_\_

Doctor \_\_\_\_\_

**THE SIU NEUROLOGY CLINIC  
PATIENT'S MEDICAL QUESTIONNAIRE  
(CONFIDENTIAL)**

(Please print or type)

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

Address: \_\_\_\_\_ SIU No: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Your Physician's Name: \_\_\_\_\_ Physicians's Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Type of practice (internist, surgeon, etc.) \_\_\_\_\_

Were you referred by your physician?  Yes  No

Shall we send a report to your physician?  Yes  No

Name and address of other physicians(s): \_\_\_\_\_

Years of Education: \_\_\_\_\_ Highest degree: \_\_\_\_\_

Marital Status: Single Married Remarried Divorced Widowed Separated

How many years \_\_\_\_\_

Primary Occupation: \_\_\_\_\_ Location: \_\_\_\_\_ Years: \_\_\_\_\_

Previous/other occupations, hobbies: \_\_\_\_\_

Exposure to hazardous materials:  Yes  No Type: \_\_\_\_\_

Last worked: \_\_\_\_\_ Are you disabled from work?  Yes  No

Reason: \_\_\_\_\_

Spouse's occupation: \_\_\_\_\_

Number of Children: \_\_\_\_\_ Ages: \_\_\_\_\_

What is the chief problem that brings you to the Clinic? \_\_\_\_\_

How long have you had the problem? \_\_\_\_\_

What do you think might be causing it? \_\_\_\_\_

**PAST MEDICAL HISTORY:**

Year	Illness or Operations	Place Hospitalized
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any blood transfusions:  Yes  No Dates: \_\_\_\_\_

Living	Age	Any known medical conditions or cause of death
Spouse:		
Children:		
Mother:		
Father:		
Sisters:		
Brothers:		

Is there a family history of any of the following in a blood relative, including parents, sisters, brothers, grandparents, aunts, uncles, etc.

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> stroke                   | <input type="checkbox"/> tuberculosis     | <input type="checkbox"/> breast cancer   | <input type="checkbox"/> kidney disease     |
| <input type="checkbox"/> heart attack/angioplasty | <input type="checkbox"/> asthma/emphysema | <input type="checkbox"/> other cancer    | <input type="checkbox"/> nervous breakdown  |
| <input type="checkbox"/> heart surgery            | <input type="checkbox"/> glaucoma         | <input type="checkbox"/> colon polyps    | <input type="checkbox"/> alcoholism         |
| <input type="checkbox"/> high blood pressure      | <input type="checkbox"/> arthritis        | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> migraine headaches |
| <input type="checkbox"/> high cholesterol         | <input type="checkbox"/> liver problems   | <input type="checkbox"/> kidney stones   | <input type="checkbox"/> epilepsy           |
| <input type="checkbox"/> diabetes                 | <input type="checkbox"/> colon cancer     | <input type="checkbox"/> memory loss     | <input type="checkbox"/> abdominal aneurysm |
| <input type="checkbox"/> parkinsonism             | <input type="checkbox"/> tremor           | <input type="checkbox"/> ataxia          | <input type="checkbox"/> other problems     |

MEDICINES: List all medicines that you have been taking recently. Include all vitamins and non-prescription medicines. Attach a separate page if necessary.

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Have you used any "recreational" drugs?  Yes  No Kind: \_\_\_\_\_

ALLERGIES or reactions to medicines or other substances. List all medications and substances.

Name of Medication: \_\_\_\_\_ Type of Reaction: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

IMMUNIZATIONS/VACCINES and Date:

- |  |  |
|--|--|
| <input type="checkbox"/> Pneumonia (pneumovax) _____ | <input type="checkbox"/> Hepatitis _____ |
| <input type="checkbox"/> Measles _____               | <input type="checkbox"/> BCG _____       |
| <input type="checkbox"/> Tetanus _____               | <input type="checkbox"/> Flu _____       |

PREVIOUS STUDIES/DATE (Bring copies of recent test and x-ray results)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Chest X-ray _____        | <input type="checkbox"/> Cat Scan Head _____  | <input type="checkbox"/> Bronchoscopy _____       |
| <input type="checkbox"/> Kidney/IVP _____         | <input type="checkbox"/> Cat Scan Other _____ | <input type="checkbox"/> Echocardiogram _____     |
| <input type="checkbox"/> Stomach/UGI _____        | <input type="checkbox"/> MRI _____            | <input type="checkbox"/> Ultrasound of _____      |
| <input type="checkbox"/> Colon/Barium Enema _____ | <input type="checkbox"/> Proctoscopy _____    | <input type="checkbox"/> Stress Test _____        |
| <input type="checkbox"/> Gall Bladder _____       | <input type="checkbox"/> Gastroscopy _____    | <input type="checkbox"/> EKG _____                |
| <input type="checkbox"/> Mammogram _____          | <input type="checkbox"/> Colonoscopy _____    | <input type="checkbox"/> Pulmonary Function _____ |
| <input type="checkbox"/> Biopsy of _____          | <input type="checkbox"/> Cystoscopy _____     | <input type="checkbox"/> Other _____              |

**PERSONAL HABITS:**

Tobacco:  Yes  No Have you ever smoked?  Yes  No

Type and amount \_\_\_\_\_ Years \_\_\_\_\_ If stopped, when? \_\_\_\_\_

Have you tried to stop?  Yes  No Do you wish to stop?  Yes  No

Alcohol: Amount (including beer, wine, and liquor) \_\_\_\_\_

Have you felt the need to cut down on alcohol?  Yes  No

Do you feel guilty about the amount of alcohol used?  Yes  No

Have you had a problem with alcohol?  Yes  No

Have you had a drink in the last 24 hours?  Yes  No

Coffee, Tea and Cola Beverages (amount per day): \_\_\_\_\_

Travel: (where and when in the last 2 years): \_\_\_\_\_

Diet: Any special diets or changes in eating habits? \_\_\_\_\_

Exercise: Any exercise?  Walking  Athletic  Other \_\_\_\_\_

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Is the purpose of this examination to determine disability status for the government or an insurance company?  Yes  No

Have you had a injury for which there is now a lawsuit pending?  Yes  No

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**Do you have any of the following:**

Recent weight gain? (amount) \_\_\_\_\_  Yes  No

Recent weight loss? (amount) \_\_\_\_\_  Yes  No

Fever or soaking sweats at night?  Yes  No

Fatigue?  Yes  No

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Weakness, numbness, tingling, cramps at night of arms or legs?  Yes  No

New, frequent or severe headaches?  Yes  No

Falls, imbalance or difficulty walking?  Yes  No

Loss of consciousness, fainting or convulsions?  Yes  No

Loss of memory or confusion?  Yes  No

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Problem with vision or eyes?  Yes  No

Date of last eye exam? \_\_\_\_\_  Yes  No

Do you wear glasses or contact lenses?  Yes  No

Head or ear noises?  Yes  No

Change in hearing?  Yes  No

Do you use a hearing aid?  Yes  No

Change in speech or voice?  Yes  No

Dizziness? ( Spinning  Lightheadedness)  Yes  No

Frequent or severe nosebleeds?  Yes  No

Trouble chewing or swallowing?  Yes  No

Sore tongue or mouth or dental problems?  Yes  No

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Daily cough or cough with bloody phlegm?  Yes  No

Short of breath after walking up two flights of stairs or hurrying?  Yes  No

Short of breath when just sitting or reclining?  Yes  No

Discomfort or pain in chest?  Yes  No

Swelling of the ankles every day?  Yes  No

Pain or tiredness in the legs while walking?  Yes  No

Any leg or foot discomfort at night?  Yes  No

High blood pressure? Years: \_\_\_\_\_  Yes  No

Recent blood pressure reading \_\_\_\_\_ / \_\_\_\_\_  Yes  No

**Do you have any of the following:**

- Abdominal pain?  Yes  No  
Frequent heartburn or indigestion?  Yes  No  
Change in bowel habits?  Yes  No  
Black or bloody bowel movements?  Yes  No  
Difficulty urinating?  Yes  No  
Do you lose control of urine at times?  Yes  No  
Awaken at night more than once to urinate?  Yes  No  
Sexual problems or changes in sex drive?  Yes  No  
Do you have any discharge?  Yes  No

- 
- Any changes in skin, moles, rash?  Yes  No  
Persistent painful, stiff or swollen joints?  Yes  No  
Back pain or discomfort?  Yes  No

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- Do you enjoy your work?  Yes  No  
How many people are in your household?  Yes  No  
Any stress or frequent conflicts at home?  Yes  No  
Do you feel anxious or depressed much of the time?  Yes  No  
Have you seriously considered suicide?  Yes  No  
Difficulty in sleeping?  Yes  No  
History of hospitalization for an emotional problem?  Yes  No

**Women Only:**

- Are menstrual periods normal?  Yes  No  
Date of last menstrual period?  Yes  No  
Bleeding between periods or after menopause?  Yes  No  
Any "hot flashes?"  Yes  No  
Any pain or dryness with intercourse?  Yes  No  
Any breast discharge?  Yes  No  
Pregnancies \_\_\_\_\_ Deliveries \_\_\_\_\_  
Miscariages \_\_\_\_\_ Abortions \_\_\_\_\_  
Approximate date of last PAP smear? \_\_\_\_\_  
Have you used hormones?  Yes  No

**Have you ever had?**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Kidney Stones             | <input type="checkbox"/> Syphilis                           |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Bladder Infection         | <input type="checkbox"/> AIDS or HIV Testing                |
| <input type="checkbox"/> Skin Cancer             | <input type="checkbox"/> Kidney Infection          | <input type="checkbox"/> Thyroid Trouble                    |
| <input type="checkbox"/> Diabetes Years _____    | <input type="checkbox"/> Radiation or Chemotherapy | <input type="checkbox"/> Tuberculosis                       |
| <input type="checkbox"/> Gonorrhea               | <input type="checkbox"/> Phlebitis or Blood Clots  | <input type="checkbox"/> Ulcer                              |
| <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Pneumonia                 | <input type="checkbox"/> Colon Polyps                       |
| <input type="checkbox"/> Heart Attack Year _____ | <input type="checkbox"/> Polio                     | <input type="checkbox"/> Sexually Transmitted Disease       |
| <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Rheumatic Fever           | <input type="checkbox"/> Migraine or other severe head pain |
| <input type="checkbox"/> Herpes                  | <input type="checkbox"/> Stroke                    |   |

Do you wear a seat belt?  Yes  No

Have we left anything out that you are concerned about or feel is important about your health? \_\_\_\_\_

\_\_\_\_\_  
Patient

(Signature)

\_\_\_\_\_  
Physician

(Reviewed By)