Neurology Associates Northwest
Patient Background Questionnaire

Name: _____ **Birthdate:** _____ **Referred by:** _____

What are the symptoms that brought you here today?: _____

_____

_____

What other physicians have you seen for this problem?: _____

Have you had any of the following diagnostic tests for this problem? If so, where?:

☐MRI or CT scan	☐ X-Ray	☐ Myelogram	☐ Angiogram
☐EEG	☐NCV/EMG	☐ LP	☐ Blood tests

Past Medical History: [Please check any conditions you have had or use the box below to describe of medical conditions.]

☐Heart disease	☐Anemia	☐Kidney disease	☐High Cholesterol	☐Thyroid disease	☐Alcoholism
☐Cancer	☐Vision	☐Lung disease	☐Blood pressure	☐Blood disorder	☐Arthritis
☐Migraine	☐Stroke	☐Diabetes	☐Epilepsy/seizure	☐Neuropathy	☐Head Injury
☐Neck trouble	☐Anxiety	☐Depression	☐Vascular Disease	☐Depression	☐Back Trouble

Surgical History: _____

_____

Medication Allergies: _____

_____

Current Medications: _____

_____

Family History:

Fathers Age: _____ **Living?:** _____ **Major Medical Conditions:** _____

Mothers Age: _____ **Living?:** _____ **Major Medical Conditions:** _____

Sibling's medical conditions: _____

_____

Children medical conditions: _____

_____

Biological relative's medical conditions: _____

_____

Marital Status: ☐Single ☐ Married ☐Widowed ☐ Divorced ☐Partner **Education Level** _____ **Regular Exercise?**: ☐ Yes ☐ No

Occupation: _____ **Time with current employer:** _____

Stress Level: Very low ……|……|……|……|……|……|……|……|……|……. Very High

Smoking: ☐ Never ☐ Quit, When? _____ ☐ Yes, How much? _____ a day

Alcohol Use: ☐ None ☐Rare ☐Light ☐Moderate ☐Heavy ☐Quit, When? _____

Street Drugs: _____ **Caffeine Use:** ☐ Yes, how much _____ a day ☐ No

Current Medical Symptoms: [Please mark & explain if you have recently had any problems with the following]

General: ☐ Fever ☐Sweats ☐Weight Gain/loss ☐Anorexia ☐Fatigue ☐Anemia ☐Bruising ☐Bleeding ☐Rash or skin lesions

Head: ☐Dizziness ☐ Headache ☐ Memory trouble

Spells: ☐ Seizures ☐ Transient Weakness ☐Numbness ☐Fainting

Vision: ☐ Blindness ☐ Blurring ☐ Double Vision ☐ Pain ☐ Light Sensitivity

Ears/Nose/Mouth: ☐Hearing ☐Ringing ☐Speaking ☐Swallowing ☐Loss of taste/smell ☐Vertigo

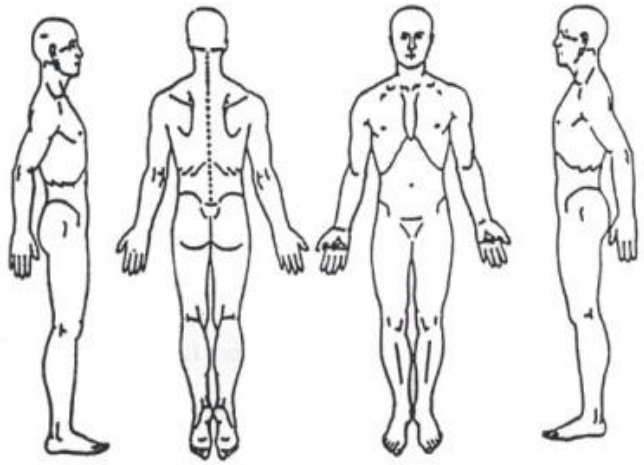
Extremities: ☐Numbness/Tingling ☐Cramping ☐Weakness ☐Imbalance ☐Walking ☐Tremor ☐Swelling ☐Arthritis

Heart/Lungs: ☐Chest Pain ☐Palpitations ☐Murmur ☐Shortness of breath ☐Asthma ☐Cough ☐Wheezing

GI: ☐Diarrhea ☐Constipation ☐Nausea ☐Vomiting ☐Jaundice ☐Bloody stool ☐Ulcer

GU: ☐Bladder/Bowel Control ☐Frequency ☐Menstrual irregularity ☐Prostate ☐Impotence ☐Sexual Dysfunction

Other: ☐Sleep Disturbance ☐Hot/Cold Intolerance ☐Anxiety ☐Panic Attack ☐Depression ☐Thirst ☐Miscarriage ☐HIV risk



Pain or sensory discomfort: [Please mark & explain your areas of discomfort]

Notes: _____

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