Beth Israel Lahey Health
Beth Israel Deaconess Needham

MRPATQ

PATIENT'S NAME _____

MED. REC. # _____

DOB _____

Patient Identification

NEUROLOGY QUESTIONNAIRE

If filled out by other than the patient, your name: _____ Date: _____

Patient name: _____ **Date of birth:** _____

Preferred phone: _____ (☐ Home ☐ Cell ☐ Other (may be family member) _____)

OK to leave voicemail? ☐ Yes ☐No OK to send appointment reminders via text? ☐ Yes ☐No

Other phone: _____ (☐ Home ☐ Cell ☐ Work) OK to leave voicemail? ☐ Yes ☐No

Primary care physician: _____

Referring physician if not your PCP: _____

What problem are you here for today? _____

Describe your medical history (current and past medical conditions, hospitalizations):

_____

_____

_____

_____

List any past surgeries:

_____

_____

Family history (please note stroke/TIA, seizure/epilepsy, migraine/ headaches, dementia/Alzheimer's, Parkinson's disease, tremor, multiple sclerosis, neuropathy, muscle disease, MS, or non-neurologic disorder)

	Living?	Age(s) now/at death	Medical problem(s)
Mother	☐ Y ☐ N		
Father	☐ Y ☐ N		
Sister(s)	☐ Y ☐ N		
Brother(s)	☐ Y ☐ N		
Daughter(s)	☐ Y ☐ N		
Son(s)	☐ Y ☐ N		

Are you working? ☐ Yes ☐ No Current or past occupation: _____

Highest level of education: _____

Family status: ☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Widowed

Partner's name and phone number: _____

Do/did you smoke? ☐ No ☐ Yes, current ☐ Yes, past If yes, for how many years? _____

Do/did you drink alcohol? ☐ No ☐ Yes, current ☐ Yes, past If yes, how many drinks per week? _____

Do/did you use drugs? ☐ No ☐ Yes, current ☐ Yes, past If yes, which? _____

Please complete both sides of the questionnaire.

MRPATQ

NEUROLOGY QUESTIONNAIRE

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Patient Identification

Review of systems: Have you had any of these symptoms recently?

Neurology

Yes	*No*		*Explain*
☐	☐	Headaches	
☐	☐	Dizziness	
☐	☐	Loss of consciousness	
☐	☐	Unresponsive episodes	
☐	☐	Memory problems	
☐	☐	Difficulty thinking	
☐	☐	Difficulty concentrating	
☐	☐	Word finding problems	
☐	☐	Other difficulty talking	
☐	☐	Slurred speech	
☐	☐	Double vision	
☐	☐	Visual spots/sparklers	
☐	☐	Facial droop	
☐	☐	Muscle weakness	
☐	☐	Tremors	
☐	☐	Other involuntary movements	
☐	☐	Muscle cramps/spasms	
☐	☐	Numbness/tingling (where?)	
☐	☐	Difficulty with hand coordination	
☐	☐	Trouble walking	
☐	☐	Balance problems	
☐	☐	Falls	

Other?

_____

_____

General

Yes	*No*	
☐	☐	Fevers/sweats (which?)
☐	☐	Weight gain/loss (which?)
☐	☐	Blurred vision
☐	☐	Light sensitivity
☐	☐	Ringing in the ears
☐	☐	Hearing loss
☐	☐	Difficulty swallowing
☐	☐	Choking
☐	☐	Voice changes
☐	☐	Palpitations
☐	☐	Chest pain
☐	☐	Lightheaded on standing
☐	☐	Cough
☐	☐	Difficulty breathing
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Stomach pain
☐	☐	Urinary urgency
☐	☐	Urinary incontinence
☐	☐	Miscarriages
☐	☐	Neck pain
☐	☐	Back pain
☐	☐	Joint aches
☐	☐	Rash
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Insomnia
☐	☐	History of clots
☐	☐	Abnormal bleeding

Please address any general symptom with your PCP if you have not already.

_____ _____ _____ _____

Patient Signature or Person Responsible to Sign | Print Name | Relationship | Date

_____ _____ _____ _____

Physician Signature | Print Name | Date | Time (24 hour)

Please complete both sides of the questionnaire.