CENTER FOR PARKINSON'S DISEASE AND OTHER MOVEMENT DISORDERS
AT COLUMBIA-PRESBYTERIAN MEDICAL CENTER, NEW YORK CITY

NEW PATIENT SUPPLEMENTARY QUESTIONNAIRE

Name (Please print):

E-mail address:

Please describe the major neurological problems you are having, and the major questions that you (or your doctor) would like to have answered. Please note if you have seen other physicians or providers for these issues.

1._____

2_____

3._____

_____

_____

_____

In addition to the medical history you already listed, have you had any of the following?

Yes No

☐ ☐ Melanoma
☐ ☐ Psychiatric hospitalization or Electroconvulsive Therapy (ECT)
☐ ☐ Memory loss or Dementia
☐ ☐ Head or neck trauma (including "blacking out", loss of consciousness)
☐ ☐ Back pain, muscle spasms
☐ ☐ Any pains over the past 24 hours.
If yes, how would you rate the intensity of pain from 0 (none) to 10 (worst pain imaginable): _____
☐ ☐ Weakness/numbness of a body part
☐ ☐ Miscarriage, abortion, or complicated pregnancy
☐ ☐ Falls?
How many falls within the past year?: _____
☐ ☐ History of taking medications for nausea, vomiting, anxiety, depression, racing thoughts, abnormal thoughts, or hallucinations? Please list: _____

Systems review: In addition to those symptoms you already listed, please circle any additional symptoms that you have had recently:

Neuro	☐ Loss of taste or smell	☐Lightheadedness on standing
	☐Decreased memory or thinking ability	☐Dizziness
	☐Trouble with reading and/or writing	☐Vertigo or sense of spinning
	☐Trouble carrying out complex tasks	☐Blurred or double vision
	☐Loss of self-confidence or change in mood	☐Headache

	☐Transient loss of vision		☐Clumsiness	
	☐Difficulty swallowing (e.g. choking or gagging)		☐Balance problem	
	☐Difficulty speaking		☐Weakness/numbness in a part of the body	
	☐Tremor or involuntary movement			
Behavioral	☐Spending more time gambling or cleaning or rearranging things			
	☐Increased eating		☐Increased sexual interest or activity	
	☐Shopping more than in the past			
Psychiatric	☐Decreased appetite		☐Loss of motivation	
General	☐ Night Sweats			
Mouth	☐Drooling of saliva	☐Dry mouth	☐Mouth ulcers	☐Watery nose
ENT	☐Ringing in the ears	☐Difficulty hearing	☐Nasal congestion	
Resp	☐Snoring			
GI	☐Black stool			
GU	☐Difficulty with erections			
Muscle -	☐Shoulder pain at any time	☐Other painful joints	☐Muscle pain or cramps	
Derm	☐Dry Skin	☐Dandruff	☐Eczema	
Endo	☐Thirsty all the time			
Heme	☐Anemia			

Please tell us more about your sleep:

Yes No

☐ ☐ Do you have vivid dreams?
☐ ☐ Do you act out your dreams such as talking, moving about a lot or kicking during sleep?
☐ ☐ Are you usually very tired during the day?
☐ ☐ Have you ever fallen asleep during the day without warning?
☐ ☐ When you try to relax in the evening or sleep at night, do you ever have unpleasant, restless feelings in your legs that can be relieved by walking or moving about?

What time you get into bed?_____
How much time before asleep? _____
What time do you wake up? _____

In addition to prescription medications already listed, what <u>other medicines or supplements</u> are you currently taking? Please include <u>nasal sprays</u>, <u>eye drops</u>, <u>hormones</u>, <u>over-the-counter pills</u>, <u>vitamins</u>, & <u>herbal supplements</u>.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Because some neurological diseases have a higher prevalence in certain population groups, we need to ask about your ethnic background. We realize this could be a sensitive subject, so if you prefer to discuss this in person, rather than responding on this questionnaire, that would be all right.

*By **ancestors**, we mean parents, grandparents, great-grandparents, great-great-grandparents, etc.*

What was the country(ies) of origin of your ancestors?

What was the religion(s) of your ancestors?

What was the race(s) of your ancestors?

Circle if a parent, sibling, child, grandparent, aunt, uncle, or cousin have (or had) any of these conditions. If so, who had it? What was their diagnosis?

Parkinson disease	Short height	Stroke or “mini strokes”
Alzheimer disease or dementia	Seizures or epilepsy	Multiple sclerosis
Tics	Migraines or headache	Brain tumor
Tremor	Early vision loss	Back problems
Dystonia	Early hearing loss	Muscle cramps
Torticollis or wry neck	Cerebral palsy	Heart or Lung disease
Facial movements	Stuttering	High blood pressure
Club foot	Scoliosis or hunchback	Thyroid disease
Huntington disease	Autism	Liver or Kidney disease
Fragile X syndrome	Immunological disorder	Diabetes
Mental Retardation	Any other neurologic disease	Women with early menopause

Is there any family history of a psychiatric disorder, alcoholism, drug abuse, depression, obsessive-compulsive disorder, “nervous breakdown,” or "nervous condition"?

If so, please make sure to include these problem(s) below:

_____

_____

_____

_____

_____

_____

Statement of Intent

We now want to introduce a very private and delicate subject. It is often easier for you if we first approach this subject in writing. Although we may not yet have examined you, we feel this subject needs to be raised. This is a good time to begin. End-of-life decisions, including brain donation, are often left to the family. However, these decisions are yours to make. Please read this statement and discuss your feelings with family and friends. Once you have had a chance to think about it, we will be glad to discuss this topic with you in person at any time.

Our Center for Parkinson's Disease and Other Movement Disorders has a commitment to diagnose and treat common and uncommon movement disorders. As part of our commitment, we are constantly searching for improved treatments for our patients. Our research, and the research of others, has already lead to improved treatments for many diseases such as Parkinson's disease, dystonia, tardive dyskinesia, Tourette syndrome, myoclonus, tremor, and others. Modern biochemical, anatomical and genetic methods have revolutionized our understanding of neurological diseases. We are proud to have participated in the successful search for the genes causing Parkinson's and dystonia and for new treatments to slow the progression of Parkinson's. Still, many of the disorders we treat have no known cause, and we have no means to slow down their worsening. Biochemical and histochemical analysis of brain tissue donated by people with movement disorders may provide the key to understanding the cause and treatment of these disorders. Therefore, a brain donation is a gift of hope. This gift of hope may provide relief for those who have symptoms now and may also provide a healthier future for generations to come.

Some patients are unsure of whether brain tissue donation is compatible with their religious beliefs. Most world religions recognize and support the concept of brain donation because the information gained has the potential to heal, "benefit the ill," or "save lives of unborn children who may have inherited a genetic disease." For additional religious guidance, please discuss your questions and concerns with your religious advisor.

We ask you now to consider brain donation in the hours after your death. This gift of brain tissue may provide a medical breakthrough. If you are willing to agree to this now, you ease the burden on your nearest kin or guardian. Because we respect whatever you decide, your decision will not have any bearing on the quality of medical care we will provide for you.

_____ **Yes**, I would be willing to donate my brain for medical progress. I have notified my next of kin that I wish to do this.
Name of next of kin _____ Relationship _____

Address _____

City _____ State _____ Zip _____

----- **Undecided**. I would like to think about this topic further. Please send me more information.
----- **Undecided**. I would like to discuss this topic with Dr. _____.
----- **No**, I do not wish to have an autopsy and donate my brain tissue for diagnostic and research purposes.

Printed Name: _____ Date of Birth: _____

Address:_____

City: _____ State: _____ Zip: _____

Signature:_____Date:_____