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

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Transient loss of vision  
Difficulty swallowing (e.g. choking or gagging)  
Difficulty speaking  
Tremor or involuntary movement 

Behavioral  
Spending more time gambling or cleaning or rearranging things 
Increased eating  
Shopping more than in the past 

Psychiatric  
Decreased appetite  

General  
Night Sweats 

Mouth  
Drooling of saliva  
Dry mouth  
Mouth ulcers  

ENT  
Ringing in the ears  
Difficulty hearing  

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  

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 other medicines or supplements are you currently taking?  
Please include nasal sprays, eye drops, hormones, over-the-counter pills, vitamins, & herbal supplements.
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
- Alzheimer disease or dementia
- Tics
- Tremor
- Dystonia
- Torticollis or wry neck
- Facial movements
- Club foot
- Huntington disease
- Fragile X syndrome
- Mental Retardation
- Short height
- Seizures or epilepsy
- Migraines or headache
- Early vision loss
- Early hearing loss
- Cerebral palsy
- Stuttering
- Scoliosis or hunchback
- Autism
- Immunological disorder
- Any other neurologic disease
- Stroke or “mini strokes”
- Multiple sclerosis
- Brain tumor
- Back problems
- Muscle cramps
- Heart or Lung disease
- High blood pressure
- Thyroid disease
- Liver or Kidney disease
- Diabetes
- 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:

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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: ____________________________

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