University of California
San Francisco

UCSF

Department of Neurology

NEW PATIENT PROFILE
NEUROLOGY

PLEASE ANSWER ALL QUESTIONS AND BRING THE COMPLETED QUESTIONNAIRE TO YOUR EVALUATION APPOINTMENT. THIS WILL HELP US PROVIDE YOU WITH THE BEST SERVICE POSSIBLE. YOUR RESPONSES TO THESE QUESTIONS WILL ASSIST THE DOCTORS IN THEIR EVALUATIONS AND WILL BE FILED IN YOUR CONFIDENTIAL MEDICAL RECORD.

YOUR NAME (First, Middle, Last):_____

Birth date:____/____/____ Male_____ Female____ Current marital status: Single____ Married____ Divorced____ Widowed_____

Are you currently employed No_____ Yes_____ If yes, specify your primary occupation:_____

If you have retired, When? Date/Year_____ Primary occupation:_____

Why are you seeking an evaluation at this time?_____

_____

Are there any recent events that have caused you concern? Please specify:

_____

_____

CURRENT MEDICATIONS

Are you currently taking any medications? No_____ Yes_____
If yes, list all current medications including over the counter medicines, herbal products, etc.

NAME OF MEDICATION	DOSE	REASON FOR TAKING	DATE PRESCRIBED

Are you allergic to any drugs? No_____ Yes_____(If yes, please list the names of all the drugs.)

_____

_____

Do you have an allergy to iodine or radiologic contrast dye? No_____ Yes_____ If so, what are the symptoms of your reaction?

_____

MEDICAL HISTORY

Have you had any operations or hospitalizations in the past? No_____ Yes_____
If yes, specify Reason for Hospitalization: Specify Date/Year

_____

DO YOU HAVE A HISTORY OF THE FOLLOWING ILLNESSES? CHECK CORRECT RESPONSE.

	Yes	No	Not Sure		Yes	No	Not Sure
Arthritis	❑	❑	❑	Loss of Consciousness/Amnesia	❑	❑	❑
Cancer	❑	❑	❑	Meningitis or Encephalitis	❑	❑	❑
Chronic Lung disease	❑	❑	❑	Psychiatric/Psychological Treatment	❑	❑	❑
Depression	❑	❑	❑	Rheumatic fever	❑	❑	❑
Diabetes	❑	❑	❑	Seizure	❑	❑	❑
Epilepsy	❑	❑	❑	Serious Head Injury	❑	❑	❑
Gallstones	❑	❑	❑	Stomach Ulcers	❑	❑	❑
Headache	❑	❑	❑	Stroke	❑	❑	❑
Heart Disease / Attack / Murmur	❑	❑	❑	Syphilis	❑	❑	❑
Hypertension/High blood pressure	❑	❑	❑	Thyroid disease	❑	❑	❑
Kidney disease / Renal Stones	❑	❑	❑	Tuberculosis	❑	❑	❑
Liver disease/Hepatitis	❑	❑	❑	History of Other Medical Problems	❑	❑	❑

If you have answered yes to any of these, please provide details and date of occurrence:

_____

_____

_____

Have you ever had a blood transfusion or received either clotting factor concentrates or platelet transfusions? No_____ Yes_____ Specify Date/Year

_____

_____

FAMILY HISTORY

Please provide the following information about your family, that is your parents, brothers, sisters and children. Please note if they have any major illness or history of brain or movement disorder. Please state cause of death if known. If you cannot answer the question, please indicate by D/K (don't know). If you have no children or sibling, please mark N/A (not applicable)

	Alive	Age	Major Illness	Deceased	Age	Cause of Death	History Brain or Movement Disorder
Mother							
Father							
Brothers							
Sisters							
Children							
Children							
Children							

If anyone above has a history of movement disorder, please provide details:

_____

_____

List any other Family Neurological Problems:

_____

_____

SOCIAL HISTORY

Do you drink alcohol? Yes_____ No_____ I have abstained since_____(date).

If yes, how much on average is your daily intake. Beer:_____ Wine:_____ Liquor:_____

Do you smoke cigarettes? Yes_____ No_____ If yes, average number of packs per day_____ Number of years_____

Have you ever used recreational drugs? Yes_____ No_____

If yes, provide details:

_____

How many grades did you complete in school?_____

REVIEW OF SYMPTOMS

Have you experienced problems with any of the following symptoms:

Mental Status	Yes	No	Don't Know
Confusion	❑	❑	❑
Poor memory	❑	❑	❑
Difficulty finding words	❑	❑	❑
Forgetting appointments	❑	❑	❑
See bright lines or flashes	❑	❑	❑
Change in sleep habits	❑	❑	❑
Difficulty reading/writing	❑	❑	❑
Difficulty chewing	❑	❑	❑
Difficulty with speech	❑	❑	❑
Loss of consciousness	❑	❑	❑

Cranial Nerves	Yes	No	Don't Know
Change in smell	❑	❑	❑
Double vision	❑	❑	❑
Blurred vision	❑	❑	❑
Temporary blindness	❑	❑	❑
Ringing in the ears	❑	❑	❑
Difficulty swallowing	❑	❑	❑
Spinning sensation	❑	❑	❑
Diminished hearing	❑	❑	❑
Altered facial sensation	❑	❑	❑
Facial weakness	❑	❑	❑

Motor	Yes	No	Don't Know
Trouble standing from a chair	❑	❑	❑
Difficulty reaching overhead	❑	❑	❑
Difficulty using hands/feet	❑	❑	❑
Loss of muscle bulk	❑	❑	❑
Involuntary shaking of hands	❑	❑	❑
Muscle twitching	❑	❑	❑
Incoordination	❑	❑	❑
Difficulty with your balance	❑	❑	❑
Muscle pain or cramps	❑	❑	❑

Sensory	Yes	No	Don't Know
Numbness or tingling of the face or body	❑	❑	❑
Numbness or tingling of the arms or legs	❑	❑	❑
Pain in the face, arms, legs, or trunk	❑	❑	❑
Difficulty controlling bowels or bladder	❑	❑	❑

Systemic	Yes	No	Don't Know
Weight gain	❑	❑	❑
Weight loss	❑	❑	❑
Intolerance to cold	❑	❑	❑
Intolerance to heat	❑	❑	❑
Sweats	❑	❑	❑
Swollen glands	❑	❑	❑
Skin rash	❑	❑	❑
Shortness of breath	❑	❑	❑
Chest pain	❑	❑	❑
Palpitations	❑	❑	❑
Nausea	❑	❑	❑
Vomiting	❑	❑	❑
Constipation	❑	❑	❑
Diarrhea	❑	❑	❑
Swollen joints	❑	❑	❑

FUNCTIONAL STATUS:

Have you experienced any change in your ability to do your usual activities at home, at work, exercising, or doing your hobbies? Yes_____ No_____
If yes, please explain:

_____

_____

Do you wish a copy of the evaluation report to be sent to your physician? Yes_____ No_____
If yes, please provide your doctor's full name and address.

_____

_____

_____

Please list all the physicians that should receive a copy of your consultation letter:

Referring Physician:_____

Tel:_____

Fax:_____

Primary Care Physician:_____

Tel:_____

Fax:_____

Other Provider:_____

Tel:_____

Fax:_____

Date of Evaluation:_____

INSTRUCTIONS TO ATTENDING PHYSICIAN:

Your signature below indicates that you have reviewed the information contained in the entire questionnaire and that you have reviewed the pertinent or key finding(s) with the patient and/or family. Key finding(s) must be summarized in your progress note, however the questionnaire may be referenced for additional details.

Attending Physician Signature Date

_____

THANK YOU FOR TAKING YOUR TIME TO COMPLETE THIS QUESTIONNAIRE.