Neurology New Patient Questionnaire
- Dr. Clifford Segil

Your Name : _____

A Medical Corporation

To all my patients,

The following questionnaire is intended to help me better evaluate and treat your neurological problems. Please fill out the front and back completely.

Thank you.

Date of Evaluation: _____ Age: _____ Date of Birth _____

Right or Left handed (please circle)

Referring physician's name: _____

Please describe the reason you are seeing the neurologist today. _____

_____

Please describe in detail the symptoms you are having. Exactly when did your problem begin? What might have caused the problem to begin? (Medical condition, stress, accident?) Please include details concerning any past diganostic tests, treatments, and responses to any past treatment.

_____

_____

_____

Have you had a MRI or CT? _____ Body part imaged _____

If yes, where was imaging done? _____ Date of scans _____

What makes this worse or better? _____

How often do you have this and how long do they last? _____

How is this problem affecting your life? What can you not do that you used to be able to do?

_____

Please list any current or past medical problems. _____

_____

Please list reasons for any overnight hospital stays, emergency room visits or urgent care visits.

_____

Please list any prior surgeries. _____

Please list any known drug allergies to past medications and what the reaction was.

_____

Please continue filling out this form on the back side of this paper.

Please list any family member's medical problems. Does anyone in your family have a history of anything similar to your primary issue you are seeing the neurologist today for?

_____

Please list any social habits like alcohol or tobacco. _____

Level of education: High School _____ College _____ Graduate _____

Marital Status: Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

Do you have to use stairs daily at home or work . If so, are you able to go and up and down?

_____

Please list current prescription medications and dosages. Please note if you have taken any medications in the past for the issue that you are seeing the neurologist today. For example if you have headaches, what has helped in the past and what has not.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you have an advanced directive such as a living will or durable power of attorney? _____

Review of Systems – Please review and then describe any positives below.

1. Constitutional symptoms: ☐ Fever/chills ☐ Fatigue ☐ Weight loss
2. Eyes: ☐ Light sensitivity ☐ Loss of vision ☐ Double vision ☐ Eye pain
3. Ears, nose, throat and mouth: ☐ Head trauma ☐ Positional dizziness ☐ Facial pain
4. Cardiovascular: ☐ Chest pain ☐ Shortness of breath ☐ Palpitations
5. Respiratory: ☐ Coughing ☐ Runny nose ☐ Wheezing/asthma
6. Gastrointestinal: ☐ Blood in stool ☐ Nausea/vomitting ☐ Diarrhea/constipation
7. Genitourinary: ☐ Frequency ☐ Retention ☐ Libido
8. Musculoskeletal: ☐ Numbness ☐ Burning pain ☐ Tingling ☐ Joint pain
   ☐ Back pain ☐ Neck pain ☐ Radiating pain down legs or hands
9. Skin and/or breast: ☐ Rashes ☐ Lesions ☐ Moles
10. Neurological: ☐ Headaches ☐ Shaking/tremor ☐ Seizures ☐ Speech problems
    ☐ Black outs ☐ Memory loss ☐ Abnormal MRI/CT ☐ Past meningitis
11. Psychiatric: ☐ Depression ☐ Thoughts of suicide ☐ Anxiety
12. Endocrine: ☐ Diabetes ☐ Hypothyroid ☐ Weight changes ☐ Thirst/Hunger
13. Hematologic/Lymphatic: ☐ Easy bruising ☐ Bleeding problems ☐ Taken Coumadin
14. Allergies: ☐ Seasonal ☐ Contact ☐ Foods

Please explain or add items._____

_____

Anything else you feel is important for me to know? _____

Thank you – Dr. Segil