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NEW PATIENT QUESTIONNAIRE

Date of First Appointment: _____/_____/_____
Month Day Year Birthplace: _____

Name: _____ Birthdate: _____/_____/_____
Last First Middle Initial Maiden Month Day Year

Address: _____ Age: _____ Sex: _____ F _____ M
Street Apt #

_____ Telephone: Home () _____
City State Zip Work () _____

Referred here by: (Check One)

_____ Self _____ Family _____ Friend _____ Doctor _____ Other Health Professional

Name of the person making the referral: _____

The name of the physician providing your general medical care? _____

Describe briefly your present symptoms: _____

Date symptoms began (approximate) _____ Diagnosis given? (Please list) _____

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later):

Please list the names of other practitioners you have seen for this problem: _____

NEUROLOGICAL HISTORY:

Trauma:

Any previous history of significant head, neck, or back injury? Yes _____ No _____

If so, please explain what and when: _____

Seizure:

Any prior history of seizure or fainting, or passing out? Yes _____ No _____

If so, When and where? _____

Infectious:

Any prior history of meningitis, encephalitis or other brain infection? Yes _____ No _____

If so, What and When? _____

Vascular:

Any prior TIAs (warning strokes)? Yes _____ No _____

Any previous strokes or stroke-like events?. Yes _____ No _____

If so when, what, where? _____

Headaches:

Any problems with headaches? Yes _____ No _____

Do you have a history of migraines? Yes _____ No _____

How many headaches do you have a month? Yes _____ No _____

What do you typically do and/or take when you have a headache? _____

Where is the headache located? _____

Vision:

Do you wear glasses? Yes _____ No _____

Do you have, or have you had, any double vision or loss of vision in just one eye? Yes _____ No _____

Vertigo:

Do you have, or have you had, any dizziness, vertigo? Yes _____ No _____

Is this a spinning sensation or a lightheaded sensation? Yes _____ No _____

Hearing:

Do you have any problems with your hearing or with ringing in your ears? Yes _____ No _____

If so, what and when? _____

Balance/Coordination:

Do you have problems with your Coordination, balance or walking? Yes _____ No _____

If so, what, and for how long? _____

Sensation:

Do you have numbness anywhere? Yes _____ No _____

If so, What, when, and where? _____

Motor:

Do you have any weakness on one side of your body? Yes _____ No _____

If so, what, when, where? _____

Taste/Smell:

Do you have any problems with taste or smell? Yes _____ No _____

Tremor/Involuntary Movement:

Do you have any tremor, shaking, jerking, sniffing, throat clearing which are involuntary? Yes _____ No _____

Bowel/Bladder:

Do you have any bladder or bowel incontinence (loss of control), urgency, or trouble with evacuation?

Yes _____ No _____

Sexual:

Do you have any problem with sexual function? Yes _____ No _____

If so, what and for how long? _____

Memory/thinking processes:

Do you have any problems with your memory, recall, thinking processes? Yes _____ No _____

If so, what and for how long? _____

Give specific examples: _____

Sleep:

Do you have problems with sleep? Yes _____ No _____

If so, what and for how long? _____

Depression/ Psychological illness:

Have you had trouble with depression or other psychological problem now or in the past?

Yes _____ No _____

How would you describe your mood over the last few weeks to months? _____

Stress:

Are you under chronic stress or do you have any new major life stress? Yes _____ No _____

MEDICAL HISTORY:

Have you had any of the following problems now or in the past?

Hypertension: Yes _____ No _____

Heart disease: Yes _____ No _____

Diabetes: Yes _____ No _____

Thyroid disease: Yes _____ No _____

Head/ Neck/ Sinus disease or injury: Yes _____ No _____

Lung disease/Asthma: Yes _____ No _____

Liver, Gallbladder: Yes _____ No _____

Stomach problems, Ulcers, Intestinal problems: Yes _____ No _____

Kidneys/Prostate/ Bladder: Yes _____ No _____

Gynecological/Female troubles: Yes _____ No _____

Rashes/ Skin lesions: Yes _____ No _____

Joint problems/Arthritis: Yes _____ No _____

Blood Abnormalities/Bleeding disorders/Anemia: Yes _____ No _____

Cancer: Yes _____ No _____

HIV risk factors: Blood transfusion, homosexual activity, IV drug use: Yes _____ No _____

Toxin/Poison exposure: Yes _____ No _____

Other: _____

PREVIOUS SURGERY:

Type	Year	Surgeon	City
1.			
2.			
3.			
4.			
5.			
6.			

Any other serious injuries? Yes _____ No _____ Please describe: _____

OTHER HOSPITALIZATIONS:

Please list any prior hospitalizations. _____

CURRENT MEDICATIONS:

Name of Drug	Dose (Please include strength and # of pills per day.)	How long have you taken this medication?	Please check: Helped?		
			A lot	Some	Not at All
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

ALLERGIES:

Drug Allergies- Yes _____ No _____ To What? _____

HABITS:

Do you smoke? Yes _____ No _____ How much per day? _____
Do you drink alcohol? Yes _____ No _____ How much per week? _____
Do you use now or in the past other recreational drugs? Yes _____ No _____
If so What, When, and how much? _____

Do you drink coffee? Yes _____ No _____ How many cups per day? _____

EMPLOYMENT:

Occupation: _____ Number of hours worked/average per week: _____

MARITAL STATUS:

Married _____ Single _____ Divorced _____

FAMILY HISTORY:

	If Living Age	Health	If Deceased Age at Death	Cause
Spouse				
Father				
Mother				

Number of brothers _____ Number living _____ Number deceased _____

Number of sisters _____ Number living _____ Number deceased _____

Number of children _____ Number living _____ Number deceased _____

List ages of each child: _____

Serious illnesses of children: _____

Do you know of any blood relative who has or has had: (check and give relationship)

Cancer	Heart disease	Rheumatic fever	Tuberculosis
Leukemia	High Blood Pressure	Epilepsy	Diabetes
Stroke	Bleeding tendency	Asthma	Alcoholism
Headaches	Lou Gehrigs (ALS)	Multiple Sclerosis	Parkinsons
Alzheimers			

GENERAL PHYSICAL EXAM:

Are you right-handed _____ Left handed _____ Ambidextrous _____

How tall are you? _____ How much do you weigh? _____

LABS:

When and where were your most recent labs done? _____

MRI:

Have you had an MRI or CT of head? Yes _____ No _____

If so, when and where? _____

MISC:

Are you receiving disability? Yes _____ No _____

Are you applying for disability? Yes _____ No _____

Do you have a medically related lawsuit pending? Yes _____ No _____