

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
MRN: \_\_\_\_\_  
Encounter #: \_\_\_\_\_

**NMG-NEUROLOGY**  
**Dr. Bega, Dr. Malkani, Dr. Melen, Dr. Opal,**  
**Dr. Simuni, and Dr. Zadikoff**  
**MEDICAL BACKGROUND AND INFORMATION FORM**

Thank you for taking the time to complete this questionnaire. Rather than taking up much of your appointment time collecting this information and taking the chance that something will be overlooked, please go through this form and fill it out to the best of your ability. This information will be reviewed with you and will help in understanding your past history and your present neurological concerns. Please answer all questions carefully and completely, as the information is very important to your care. Please bring this form with you to your first doctor's visit.

**DATE:** \_\_\_\_\_

Age: \_\_\_\_\_

Tel. # Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**List your physicians, including addresses, zip codes and phone numbers. Put a \* by your primary physician so that a report of your visit may be sent to him or her.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you naturally: right-handed\_\_\_\_ left-handed\_\_\_\_ ambidextrous\_\_\_\_

\*\*\*\*\*

**Have you been diagnosed with Parkinson's Disease? Y/N.**

***If you have NOT been diagnosed, skip to the section on Medical History.***

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**Early Symptoms**

What were your initial symptoms? Tremor\_\_\_\_ Balance problems\_\_\_\_

Slow or clumsy movement\_\_\_\_ Small handwriting\_\_\_\_

What side of the body was involved? Right\_\_\_\_ Left\_\_\_\_ Both\_\_\_\_

What year did the symptoms begin?\_\_\_\_ What year were you diagnosed?\_\_\_\_

**Parkinson's Medication History**

Most of the medications used to treat Parkinson's disease are listed on the next page. For each drug you have ever taken, please indicate if it was helpful or of no benefit, and any side effects which may have occurred when you took it. If you have records available, the dosage information is very helpful.

**\*\*Please complete this checklist if you have ever received or are currently receiving treatment for Parkinson's disease.**

<i>Drug Name</i>	<i>Maximum Dose</i>	<u><i>Beneficial?</i></u>		<i>Side Effects</i>
		<i>Yes</i>	<i>No</i>	
Selegiline (Eldepryl)	_____	_____	_____	_____
Amantidine	_____	_____	_____	_____
Sinemet (Carbidopa-Levodopa)	_____	_____	_____	_____
Sinemet CR	_____	_____	_____	_____
Comtan	_____	_____	_____	_____
Tasmar	_____	_____	_____	_____
Permax	_____	_____	_____	_____
Mirapex	_____	_____	_____	_____
Requip	_____	_____	_____	_____
Parlodel	_____	_____	_____	_____
Artane	_____	_____	_____	_____
Azilect	_____	_____	_____	_____
Neupro patch	_____	_____	_____	_____
Cogentin	_____	_____	_____	_____

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**Medical History (All patients please complete)**

Please list all medical conditions, including date of onset, for which you see a doctor or for which you have seen a doctor in the past (i.e.—high blood pressure, diabetes, cardiac problems, depression).

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

**Operations and Hospitalizations**

Please list all operations and hospitalizations starting with the most recent.

<i>Surgery or Hospitalization</i>	<i>Date</i>	<i>Surgery or Hospitalization</i>	<i>Date</i>

**Current Medications (including vitamins and supplements)**

<i>Medication</i>	<i>Dosage</i>	<i>How Often</i>

**Drug Allergies**

<i>Medication</i>	<i>Allergic Response</i>

**Side Effects of Current Medications (check all that apply)**

- |   |   |
|---|---|
| <input type="checkbox"/> Drug doesn't last long enough          | <input type="checkbox"/> Insomnia       |
| <input type="checkbox"/> Involuntary movements from drugs       | <input type="checkbox"/> Confusion      |
| <input type="checkbox"/> Sleepiness/drowsiness from medications | <input type="checkbox"/> Memory loss    |
| <input type="checkbox"/> Frequent falls                         | <input type="checkbox"/> Depression     |
| <input type="checkbox"/> Nightmares                             | <input type="checkbox"/> GI upset       |
| <input type="checkbox"/> Hallucinations                         | <input type="checkbox"/> Bowel problems |

**Any other problems with medications?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Social History**

Education Level: \_\_\_\_\_

Marital Status: S M Sep W D Partnered Occupation: \_\_\_\_\_

Employed: Y/N Retired: Y/N If yes, at what age? \_\_\_\_\_ Hours worked per week: \_\_\_\_\_

Where do you live? Own home\_\_ Apartment\_\_ Assisted Living\_\_ Nursing Home\_\_

With whom do you live? Alone\_\_ With spouse\_\_ With family member(s)\_\_ Other\_\_

How is your spouse's health? \_\_\_\_\_

Any history of exposure to welding materials? Y/N

Do you smoke? Y/N. If yes, cigarettes \_\_\_\_\_ # packs per day \_\_\_\_\_ cigars \_\_\_\_\_ pipe \_\_\_\_\_

Do you drink alcohol? Y/N. If yes, how much? \_\_\_\_\_

Do you use any other drugs? Y/N. If yes, please list: \_\_\_\_\_

**Family History**

Relative	Sex	Age	Health Problems	Age at death	Cause of death
Mother	F				
Father	M				
Siblings					
Siblings					
Siblings					
Children					
Children					
Children					

**Any relatives with Parkinson's disease or any other neurological illnesses?**

\_\_\_\_\_

\_\_\_\_\_

**Review of Systems**

Have you ever experienced any of the following symptoms?

Symptoms	Yes	No	Symptoms	Yes	No
Persistent fevers			Impotence		
Unexplained weight loss			Loss of vision		

Rashes			Double vision		
Joint pain			Hearing loss		
Easy bruising			Ringing in ears		
Blood clots in legs or lungs			Persistent dizziness		
Miscarriage			Difficulty swallowing		
Skin or hair changes			Difficulty talking		
Allergies			Leg or arm weakness		
Sinusitis			Numbness in arms or legs		
Neck pain			Trouble walking		
Low back pain			Head trauma		
Difficulty breathing			Headaches		
Chest pain			Seizures		
Palpitations			Memory loss		
Persistent diarrhea			Trouble sleeping		
Persistent vomiting			Anxiety or depression		
Discolored urine			Tremor		
Bowel or bladder accidents			Balance problems		

### Experimental Drug Studies

We always have studies in progress investigating new drugs or new applications for approved medications. Do you have any interest in learning about these studies or possibly participating in a drug evaluation? \_\_\_\_yes \_\_\_\_no

Please include any additional information that you feel may be helpful for us to know:

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