

Date Today: _____ NAME: _____ NRC #: _____

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INITIAL VISIT FORM

Please list the symptoms of your neurological problem and all medical information about yourself and your family.
Please complete all pages by using blue or black ink only.

PATIENT

Name: _____
Address: _____

Date of Birth: ____ . ____ . ____
Phone: ____ - ____ - ____
Fax: ____ - ____ - ____
E-mail: _____
Place of birth: _____
Nationality or race of Parents: _____
Employment: _____

Referring physician

Name: _____
Address: _____

Phone: ____ - ____ - ____
Fax: ____ - ____ - ____
E-mail: _____

Primary Care Physician

Name: _____
Address: _____

Phone: ____ - ____ - ____
Fax: ____ - ____ - ____
E-mail: _____

LIST AND DESCRIBE THE NATURE AND DURATION OF YOUR NEUROMUSCULAR SYMPTOMS:

1. _____
2. _____
3. _____
4. _____
5. _____

Other problems you want us to know about?

1. _____
2. _____
3. _____
4. _____

Health Questionnaire. Please check **yes** or **no** after each question

Due you have any of the following neurological symptoms ?

Memory problems?	Yes___ No___	Muscle pain/cramps?	Yes___ No___	Muscle wasting?	Yes___ No___
Bad headaches?	Yes___ No___	Low back pain?	Yes___ No___	Muscle weakness?	Yes___ No___
Fainting or blackouts?	Yes___ No___	Neck Pain?	Yes___ No___	Muscle fatigue?	Yes___ No___
Convulsions?	Yes___ No___	Involuntary movements?	Yes___ No___	Swallowing problems?	Yes___ No___
Numbness in hands?	Yes___ No___	Coordination problems?	Yes___ No___	Speech difficulty?	Yes___ No___
Numbness in feet?	Yes___ No___	Balance problems?	Yes___ No___	Breathing difficulty?	Yes___ No___
Visual problems?	Yes___ No___				
Other symptoms?	_____				

Allergy to medication, X-ray contrast dye or latex: Yes___ No___

Agent	Type of reaction
_____	_____
_____	_____
_____	_____
_____	_____

Date Today: _____ NAME: _____ NRC #: _____

Treated for anemia in the past year?	Yes___ No___	Other general symptoms: _____
Loss of appetite?	Yes___ No___	_____
Has your weight changed more than 10 pounds in the past year?	Yes___ No___	
Have you had a fever (temperature greater than 100) in the past month?	Yes___ No___	

Rheumatism or arthritis?	Yes___ No___	Joint swelling	Yes___ No___	Joint pains?	Yes___ No___
Other rheumatological problems: _____					

Difficulty with hearing?	Yes___ No___	Noises in the ears?	Yes___ No___	Dizziness?	Yes___ No___
Frequent head colds?	Yes___ No___	Frequent sinus trouble?	Yes___ No___	Persistent hoarseness?	Yes___ No___
Frequent nose bleeds?	Yes___ No___	Other Ear Nose and Throat symptoms: _____			

Daily cough?	Yes___ No___	Coughed up blood?	Yes___ No___
Coughed up much phlegm or sputum?	Yes___ No___	Asthma?	Yes___ No___
Pneumonia or severe bronchitis?	Yes___ No___	Other respiratory problems? _____	
Short of breath when walking or working?	Yes___ No___		

Chest pains?	Yes___ No___	Feet or leg is swelling at end of day?	Yes___ No___
Chest pressure or tightness when excited?	Yes___ No___	Doctor ever said heart trouble?	Yes___ No___
when walking or working?	Yes___ No___	Does your heart thump or race?	Yes___ No___
Other cardiac symptoms? _____			

Skin rash?	Yes___ No___	Frequent itching of skin?	Yes___ No___
Easy bruising of skin?	Yes___ No___	Other dermatological problems? _____	

Heartburn?	Yes___ No___	Indigestion or stomach trouble?	Yes___ No___
Colon polyps?	Yes___ No___	Frequently constipated?	Yes___ No___
Bleeding from the rectum in the past?	Yes___ No___	Frequent diarrhea or dysentery?	Yes___ No___
Doctor ever said stomach or duodenal ulcer?	Yes___ No___	Other Gastrointestinal trouble? _____	
Doctor ever said gallbladder trouble?	Yes___ No___	_____	
Doctor ever said jaundice?	Yes___ No___		

Waken more than once from sleep to urinate?	Yes___ No___	Burning or pain when urinating?	Yes___ No___
Trouble starting urination?	Yes___ No___	Blood in the urine?	Yes___ No___
Trouble emptying your bladder completely?	Yes___ No___	Passed a kidney stone in your urine?	Yes___ No___
Treated for a urine infection in the past year?	Yes___ No___	Other genitourinary symptoms? _____	

Have trouble sleeping (insomnia)?	Yes___ No___	Frequently feel nervous or upset?	Yes___ No___
Ever had a nervous breakdown?	Yes___ No___	Feel discouraged or depressed?	Yes___ No___
Difficulties in your sex life?	Yes___ No___	Other Psychiatric problems: _____	

Had thyroid trouble?	Yes___ No___	Other endocrine problems: _____
Taken any of these medication in the past year _____		
hormone shots or pills?	Yes___ No___	_____
thyroid medication?	Yes___ No___	_____
insulin or diabetes medicine?	Yes___ No___	
cortisone or similar medicine?	Yes___ No___	

Most recent sigmoidoscopic or proctoscopic examination: _____	Normal___	Abnormal___
Vaccination history (type and date) 1. _____ 2. _____		
3. _____ 4. _____		
5. _____ 6. _____		

WOMEN		
Abnormal Pap Smear? Yes___ No___	Last Pap smear? _____	Last menstrual period? _____
Recent Mammogram? _____	Number of pregnancies? _____	Number of miscarriages? _____
Periods? Regular___ Irregular___		

