

Dr. Olinka Hrebicek
Neurology

Please answer the following questions:

E-mail: _____ **GP/Walk-in clinic:** _____

Name: _____ **Age:** _____ **Height:** _____ **Weight:** _____

Handedness: [] Right [] Left

What is/was your occupation: _____

Are you married/live with a partner? [] Yes [] No. How many children do you have? _____

Neurological concerns (**why** you are here today and **when** did the problem start):

Please put an "X" beside the conditions/illnesses you have had:

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Head injuries	<input type="checkbox"/> Lupus
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Migraine headaches
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Peptic ulcer disease
<input type="checkbox"/> Bleeding tendency	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Blood clots	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Sleep apnea
<input type="checkbox"/> Cancer	<input type="checkbox"/> HIV	<input type="checkbox"/> STI _____
<input type="checkbox"/> Depression	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes	<input type="checkbox"/> IBD/Crohn's disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Drug addiction _____	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Other _____
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney disease	_____

How much alcohol do you consume in a week? _____. Have you quit previously? _____

Do you smoke? _____. If you have quit, when? _____

Recreational drug use: [] never [] now [] in the past: which drugs _____

Previous injuries: _____

List all prescription medications (including all dosage details) you currently take:

Pharmacy Name/Location/Telephone: _____

List any over-the-counter drugs, supplements, herbs, or vitamins that you take: _____

List medication **allergies** and reactions (i.e. rash) you have had: _____

List any significant diseases that run in your family (i.e. diabetes, strokes, migraines, neurological diseases): _____

“Review of Systems”

Have you had any of the following recently (please indicate with an “X”)?

<p><u>Cardiovascular</u></p> <p><input type="checkbox"/> palpitations</p> <p><input type="checkbox"/> blue painful hands</p> <p><input type="checkbox"/> feeling faint</p> <p><input type="checkbox"/> chest pains</p> <p><u>Constitutional</u></p> <p><input type="checkbox"/> weight loss</p> <p><input type="checkbox"/> loss of appetite</p> <p><input type="checkbox"/> fever</p> <p><input type="checkbox"/> night sweats</p> <p><input type="checkbox"/> headache</p> <p><input type="checkbox"/> fatigue</p> <p><input type="checkbox"/> heat or cold intolerance</p> <p><input type="checkbox"/> sleep changes such as insomnia, vivid dreaming and/or acting out</p> <p><u>ENT</u></p> <p><input type="checkbox"/> deafness</p> <p><input type="checkbox"/> spinning dizziness</p> <p><input type="checkbox"/> ringing in the ears</p> <p><input type="checkbox"/> discharge from the ears</p> <p><input type="checkbox"/> nasal bleeding</p> <p><input type="checkbox"/> trouble swallowing</p> <p><input type="checkbox"/> change in your voice</p> <p><input type="checkbox"/> pain chewing food</p> <p><input type="checkbox"/> sinus problems</p> <p><input type="checkbox"/> loss of smell/taste</p> <p><input type="checkbox"/> dry mouth</p> <p><u>Eyes</u></p> <p><input type="checkbox"/> eye pain</p> <p><input type="checkbox"/> tearing</p> <p><u>Gastrointestinal</u></p> <p><input type="checkbox"/> diarrhea</p> <p><input type="checkbox"/> vomiting</p> <p><input type="checkbox"/> swallowing problems</p> <p><input type="checkbox"/> black stool</p> <p><input type="checkbox"/> blood in your stool</p> <p><input type="checkbox"/> loss of bowel control/constipation</p>	<p><u>Genitourinary</u></p> <p><input type="checkbox"/> loss of bladder control</p> <p><input type="checkbox"/> urinating too frequently</p> <p><input type="checkbox"/> getting up at night to urinate</p> <p><input type="checkbox"/> pain when urinating</p> <p><input type="checkbox"/> blood in the urine</p> <p><input type="checkbox"/> impotence/sexual dysfunction</p> <p><input type="checkbox"/> menstrual change</p> <p><u>Hematologic</u></p> <p><input type="checkbox"/> bruising</p> <p><input type="checkbox"/> easy bleeding</p> <p><input type="checkbox"/> frequent infections</p> <p><u>Musculoskeletal</u></p> <p><input type="checkbox"/> arthritis</p> <p><input type="checkbox"/> joint pain/ache</p> <p><input type="checkbox"/> muscle pain/ache</p> <p><input type="checkbox"/> change in size of feet/hands</p> <p><u>Neurologic</u></p> <p><input type="checkbox"/> mood change</p> <p><input type="checkbox"/> depression/anxiety</p> <p><input type="checkbox"/> tingling in the arms/legs</p> <p><input type="checkbox"/> memory loss or slowed thinking</p> <p><input type="checkbox"/> reduced arm swing while walking</p> <p><input type="checkbox"/> change in handwriting</p> <p><input type="checkbox"/> shaking of the hand(s), arm(s), leg(s), lips, or jaw while at rest or with action</p> <p><u>Respiratory</u></p> <p><input type="checkbox"/> shortness of breath</p> <p><input type="checkbox"/> wheezing</p> <p><u>Skin</u></p> <p><input type="checkbox"/> rash</p> <p><input type="checkbox"/> breast lump</p> <p><input type="checkbox"/> breast discharge/milk</p> <p><input type="checkbox"/> hair loss</p> <p><input type="checkbox"/> pain combing your hair</p> <p><input type="checkbox"/> coloured spots on your skin</p>
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Headache Questionnaire

Name: _____

Length of time you have suffered from headaches: _____ Days _____ Months _____ Years

Headache duration

< 2 hrs 2 – 72 hrs over 72 hrs

Frequency (headaches per month)

< 2 < 4 < 8 < 16 > 16

Site of pain

One side Both sides Beginning on one side and spreading to the other

Type of pain

Throbbing/Pulsating Burning Tightening or pressing Goes away with sleep

Severity of pain

Mild Moderate Severe

Is the pain aggravated by routine physical activity? Yes No

Other symptoms:

Nausea Sensitivity to light
 Vomiting Sensitivity to smell
 Aura i.e. Flashes of light or blurred vision or “zig-zag” patterns Sensitivity to sound

How many days in the last month did you have a headache? _____ Days

Have you identified any migraine triggers? _____.

On a scale of 0 – 10, on average how painful were these headaches?
(0 = no pain at all, and 10 = pain as bad as it can be)

0 1 2 3 4 5 6 7 8 9 10

How many days in the last 3 months did you miss work or school, or your productivity was reduced by half because of your headaches? _____ Days

How many days in the last 3 months did you NOT do work around the house, or your productivity was reduced by half because of your headaches? _____ Days

How many days in the last 3 months did you miss family, social, or leisure activities because of your headache? _____ Days

In a month how many days are you **completely free** of headaches? _____ Days

Have you had new or different headaches in the past 6 months? Yes No

Please mark the preventative and abortive agents you have tried.

Preventative Agents

Dose

<input type="checkbox"/> Betablocker such as Propranolol, Nadolol Metoprolol, or Atenolol	
<input type="checkbox"/> Nortriptyline, Amitriptyline	
<input type="checkbox"/> Topiramate (Topomax)	
<input type="checkbox"/> Gabapentin (Neurontin)	
<input type="checkbox"/> Epival (Divalproex sodium) Valproic Acid (Depakene)	
<input type="checkbox"/> Verapamil, Flunarizine (Sibelium)	
<input type="checkbox"/> Cymbalta (Duloxetine)	
<input type="checkbox"/> Effexor (Venlafaxine)	
<input type="checkbox"/> Sandomigran	
<input type="checkbox"/> Other	

Abortive Agents

Dose

<input type="checkbox"/> Sumatriptan (Imitrex)	
<input type="checkbox"/> Zolmitriptan (Zomig)	
<input type="checkbox"/> Frovatriptan (Frova)	
<input type="checkbox"/> Eletriptan (Relpax)	
<input type="checkbox"/> Naratriptan (Amerge)	
<input type="checkbox"/> Rizatriptan (Maxalt)	
<input type="checkbox"/> Almotriptan (Axert)	
<input type="checkbox"/> Tylenol (Acetaminophen)	
<input type="checkbox"/> Non-steroid anti-inflammatory medication – (i.e., Naproxen)	

Non-Pharmacological Treatments

<input type="checkbox"/> Acupuncture
<input type="checkbox"/> Chiropractic Therapy
<input type="checkbox"/> Massage
<input type="checkbox"/> Physiotherapy
<input type="checkbox"/> Other

Thank you for taking the time to complete this questionnaire

PHQ-9 – Nine Symptom Checklist

Name: _____ Date: _____

Over the last **2 weeks**, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things

Not at all Several days More than half the days Nearly every day

2. Feeling down, depressed, or hopeless

Not at all Several days More than half the days Nearly every day

3. Trouble falling or staying asleep, or sleeping too much

Not at all Several days More than half the days Nearly every day

4. Feeling tired or having little energy

Not at all Several days More than half the days Nearly every day

5. Poor appetite or overeating

Not at all Several days More than half the days Nearly every day

6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down

Not at all Several days More than half the days Nearly every day

7. Trouble concentrating on things, such as reading the newspaper or watching television

Not at all Several days More than half the days Nearly every day

8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual

Not at all Several days More than half the days Nearly every day

9. Thoughts that you would be better off dead or of hurting yourself in some way

Not at all Several days More than half the days Nearly every day

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not at all Several days More than half the days Nearly every day

GAD-7 Screening Questions

Name: _____ Date: _____

During the last **2 weeks**, how often have you been bothered by the following problems?

1. Feeling nervous, anxious, or on edge

Not at all Several days More than half the days Nearly every day

2. Not being able to stop or control worrying

Not at all Several days More than half the days Nearly every day

3. Worrying too much about different things

Not at all Several days More than half the days Nearly every day

4. Trouble relaxing

Not at all Several days More than half the days Nearly every day

5. Being so restless that it is hard to sit still

Not at all Several days More than half the days Nearly every day

6. Becoming easily annoyed or irritable

Not at all Several days More than half the days Nearly every day

7. Feeling afraid, as if something awful might happen

Not at all Several days More than half the days Nearly every day

If you off checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult