HARTFORD NEUROLOGY, LLC
Patient Questionnaire Form

Patient Name:_____ Date:_____

Date of Birth: _____ Age: _____ PCP: _____

Current Weight: _____ Height: _____

SYSTEM REVIEW

CONSTITUTIONAL SYMPTOMS		
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
EYES		
Visual loss	No	Yes
Glaucoma	No	Yes
EARS/NOSE/MOUTH/THROAT		
Hearing loss	No	Yes
Ringing in the ears	No	Yes
CARDIOVASCULAR		
Heart trouble	No	Yes
Lightheaded or dizziness	No	Yes
Chest pain or angina	No	Yes
Palpitations	No	Yes
Swelling in the feet or ankles	No	Yes
RESPIRATORY		
Chronic or frequent cough	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes
COPD	No	Yes
Sleep Apnea	No	Yes
GASTROINTESTINAL		
Rectal bleeding or blood in stool	No	Yes
Abdominal pain or heartburn	No	Yes
Peptic ulcer disease	No	Yes
GENITOURINARY		
Painful urination	No	Yes
Frequent urination	No	Yes
Change in force of stream when urinating	No	Yes
Incontinence or dribbling	No	Yes
Nephrolithiasis (kidney stones)	No	Yes
Henaturia (blood in urine)	No	Yes
Recurrent Urinary Tract Infection	No	Yes

MUSCULOSKELETAL		
Joint pain or swelling	No	Yes
Muscle Weakness	No	Yes
Muscle pain or cramps	No	Yes
Low Back pain	No	Yes
Neck Pain	No	Yes
INTEGUMENTARY/SKIN and BREAST		
Rash or itching	No	Yes
NEUROLOGICAL		
Frequent or recurring headaches	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head injury	No	Yes
Difficulty walking	No	Yes
Memory loss	No	Yes
Daytime sleepiness	No	Yes
PSYCHIATRIC		
Depression	No	Yes
Anxiety	No	Yes
ENDOCRINE		
Thyroid disease	No	Yes
Diabetes	No	Yes
HEMATOLOGICAL/LYMPHATIC		
Anemia	No	Yes
Past blood transfusion	No	Yes

ALLERGIES:
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_____
_____
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_____
_____

Physician Note:

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MEDICATION LIST: ***include dosage & instructions***
