BOULDER MEDICAL CENTER, P.C.

Department of Neurology

New Patient Questionnaire

Please complete the form below with as much information as possible and bring it with you to your first appointment.

Name_____

Date of Birth_____

Name of referring doctor_____

Please briefly describe the reason for your appointment

_____

_____

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_____

_____

Please list the main questions you would like me to answer

_____

_____

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_____

Have you been seen by another neurologist in the past? YES* NO

*If yes: Name of doctor_____

Date: _____

Have you had any pictures (Xray, CT, MRI) of your brain or spine, or neurologic testing (EEG, EMG, neuropsych testing)? YES* NO

*If yes, please list the type of test, date it was done, and facility where it was performed.

_____

_____

_____

_____

_____

*Please request that copies of records and test results be sent to our office prior to your appointment. Fax: (303) 440-3209.

Medications:

Please list the medications you are taking, including the dose, and when you take them. Please include over the counter medications and supplements (If you already have a list, you may bring it with you for us to copy)

Medical history:

Have you ever been diagnosed with:

Diabetes	YES	NO
Heart disease	YES	NO
Asthma/COPD	YES	NO
Cancer	YES	NO
Thyroid disease	YES	NO
Fibromyalgia	YES	NO
Depression/Anxiety	YES	NO
Psychiatric illness	YES	NO
Stroke/TIA	YES	NO
Arthritis	YES	NO
Dementia/Alzheimer's	YES	NO
Parkinson's Disease	YES	NO
Multiple Sclerosis	YES	NO
Liver Disease	YES	NO
Kidney Disease	YES	NO

Surgical History: Please list any surgeries you have had:

_____

_____

_____

_____

_____

Social history:

Do you smoke (tobacco or marijuana)? YES NO

How much?_____

For how long? _____

Do you drink alcohol? YES NO

How many drinks per week?_____

Do you use any other non-prescription drugs? YES NO

Do you work outside the home? YES NO

What do you do?_____

Are you retired? YES NO

What did you previously do?_____

Family history:

Has anyone in your family (parents, siblings, and children) been diagnosed with:

Stroke	YES	NO
Diabetes	YES	NO
Parkinson's Disease	YES	NO
Dementia/Alzheimer's	YES	NO
Multiple Sclerosis	YES	NO
Aneurysm	YES	NO
Muscle/Nerve Disorder	YES	NO
Seizures	YES	NO
Other Neurologic conditions	YES	NO