Robert Wood Johnson Medical School

Department of Neurology
Health Questionnaire & Review of Systems

Note to Patient: This form is a part of your Medical Record. Please complete both sides of Questionnaire

NAME: ______________________________ DATE: ____________

D.O.B: ____________________ AGE: ______________

Are you **RIGHT** handed or **LEFT** handed? (Circle one)

Reason for visit: ______________________________

____

Past History: List any Medical Problems you are treated for:

____

____

List any surgeries you have had:

____

____

Medications: (List **ALL** medications you are taking and the amount)

____

____

Allergies: (List **ALL** medications to which you are allergic- *Examples: Sulfa, Penicillin, Codeine, Aspirin)*
(List any **Environmental** and **Food** Allergies)

____

Family History: (Blood Relative ONLY- List Conditions)

____

Social History: _____ Married ____ Single _____ Divorced _____ Widowed

How many years of formal education have you completed? __________
Present Employment status: _____ Full-time _____ Part-Time _____Unemployed _____Retired _____ Disabled
What is/Was your occupation? ______________________________

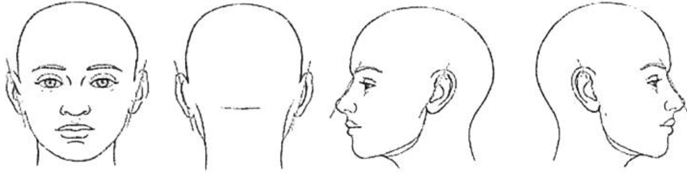
Did you ever smoke or use tobacco? ☐ No ☐ Yes
If YES, packs per day: ______ For how many years?: ______
Did you quit? ______ If YES, when? ______
How frequently do you consume alcoholic beverages?
_____Never _____1-7 Drinks/Week _____ More than 7 drinks/week
Have you traveled outside of the USA in the last 12 months? ☐ No ☐ Yes

SYSTEMIC SYMPTONS: **PHYSICIAN NOTE:**

Headache History & Profile

NAME: DATE OF BIRTH: DATE:

On what part of the head do the headaches start? **Use diagrams to indicate**



_____ (R) Side _____ (L) Side _____ Either Side _____ Both Sides

_____ Back _____ On Top _____ Temples _____ Behind/Around Eyes

_____ Forehead _____ Face _____ Neck _____ Other

After the headache starts, Does it usually: _____Stay in one place? _____ Move around? Please explain.

____

____

How would you describe the pain? _____ Throbbing/Pulsating _____Pressing/Squeezing _____Stabbing

_____ Dull/Nagging _____ Sharp _____ Other

Describe the degree of paint **(circle one #)** - slight - 1 2 3 4 5 6 7 8 9 10 - worst imaginable

Do your headaches interfere or prevent normal activities, work, etc.? ☐ No ☐ Yes

How long ago did the current headaches start? _____Weeks _____ Months _____Years

How old were you when any headache started? _____

How long does the headache usually last? _____ Minutes ____ Hours _____ Days _____ Constant

How often does the headache occur? _____ x/Day _____ x/Week _____x/Month _____x/Year _____x/Constant

Does the headache awaken you from sleep? ☐ No ☐ Yes

Is the headache getting _____worse? _____ better? _____ fluctuating? _____ no change

---

Are any of the following symptoms associated with the headaches? Please Mark: **(B) before (✓) during (A) after**

_____Spots before eyes –type-
_____ Blindness (R/L)
_____ Blurring (R/L)
_____Double vision
_____ Can see only half objects
_____ Eyelid droop (R/L)
_____ Tearing (R/L)
_____ Eye Redness (R/L)
_____ Eyes Puffy (R/L)

_____ Light Sensitivity
_____ Noise Sensitivity
_____ Odors Sensitivity
_____ Nose Blocked/ Discharge (R/L)

_____ Nausea _____ Vomiting
_____ Loss of Appetite _____ Hunger
_____ Cramps _____ Diarrhea

-Face-Scalp-

_____ Pale _____Redness
_____ Sweating _____ Tender
_____ Puffy _____ Pain on Chewing
_____ Decreased jaw opening

-Neck-

_____ Stiff _____Tender
_____ Difficulty Concentrating
_____ Depression _____ Anxiety
_____ Fatigue _____ Irritability

Weakness (W) Numbness (N) Both (B)

_____Face (R/L) _____ Arms (R/L)
_____ Arm & Leg (R/L) _____Legs (R/L)
_____ Difficulty talking (finding words)
_____ Difficulty Understanding
_____ Numbness around lips
_____ Slurred Speech
_____ Fainting (feel like/have fainted)
_____ Dizzy:
(lightheaded/unsteady/spinning)

-Hands and/or Feet-

_____ Cold _____Pale
_____ Sweaty _____Mottled

Ear/Nose/Throat Problems ______Yes ______ No ______________________________
Fever ______Yes ______ No ______________________________
Weight Loss (Unexplained) ______ Yes ______ No ______________________________
Severe ______ Yes ______ No ______________________________

CARDIOVASCULAR:

Presence of Chest Pain or Pressure ______ Yes ______ No ______________________________
Irregular Heart Beat ______ Yes ______ No ______________________________
Dizziness/Fainting ______ Yes ______ No ______________________________
Swelling of the Feet ______ Yes ______ No ______________________________
Blood Clots in the Legs or Lungs ______ Yes ______ No ______________________________

RESPIRATORY:

Cough ______ Yes ______ No ______________________________
Difficulty Breathing ______ Yes ______ No ______________________________

GASTROINTESTINAL:

Nausea or Vomiting ______ Yes ______ No ______________________________
Blood in Stool ______ Yes ______ No ______________________________
Difficulty in Swallowing ______ Yes ______ No ______________________________
Change in Bowel Habits ______ Yes ______ No ______________________________
Loss of Appetite ______ Yes ______ No ______________________________

GENITOURINARY:

Urinary Problems ______ Yes ______ No ______________________________
Problems with Sexual Function ______ Yes ______ No ______________________________

MUSCULOSKELETAL:

Joint Stiffness or Swelling ______ Yes ______ No ______________________________
Muscular Pain/Cramps ______ Yes ______ No ______________________________
Back Pain ______ Yes ______ No ______________________________
Varicose Veins ______ Yes ______ No ______________________________
Skin Problems ______ Yes ______ No ______________________________

PSYCHIATRIC:

Depression ______ Yes ______ No ______________________________
Agitation ______ Yes ______ No ______________________________
Anxiety/Nervous Disorder ______ Yes ______ No ______________________________
Memory Problems ______ Yes ______ No ______________________________

ENDOCRINE:

Excessive Urination ______ Yes ______ No ______________________________
Excessive Thirst ______ Yes ______ No ______________________________
Cold/Heat Intolerance ______ Yes ______ No ______________________________
For Women Only-Onset of Menopause ______ Yes ______ No ______________________________

HEMATOLOGIC/LYMPHATIC:

Bleeding Problems or Easy Bruising ______ Yes ______ No ______________________________

____ ______________________________
(Signature of Individual completing form) (Relationship to patient)

I have reviewed this form with the patient: ______________________________________ Date: ______________
(Physician Signature)