Neurological & Vascular Patient Questionnaire

NAME:_____ **DATE:**_____

For any YES answer, please notify the Doctor:

1. Do you suffer from neck pain with pain in your shoulder, arms, elbows or hands? ☐NO ☐YES
   Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? ☐NO ☐YES
   Comment: _____
3. Do your hands or arms fall asleep regularly? ☐NO ☐YES
   Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? ☐NO ☐YES
   Comment: _____
5. Do you suffer from a loss of hand grip strength? ☐NO ☐YES
   Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs, knees or feet? ☐NO ☐YES
   Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? ☐NO ☐YES
   Comment: _____
8. Do your legs or feet fall asleep regularly? ☐NO ☐YES
   Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? ☐NO ☐YES
   Comment: _____
10. Do you suffer from cold hands or feet? ☐NO ☐YES
    Comment: _____
11. Do you suffer from headaches, dizziness or memory loss? ☐NO ☐YES
    Comment: _____
12. Do you have difficulty maintaining your balance? ☐NO ☐YES
    Comment: _____
13. Do you suffer from vertigo or blurred vision? ☐NO ☐YES
    Comment: _____
14. Do you suffer from a reduced hearing capacity? ☐NO ☐YES
    Comment: _____
15. Do you suffer from ringing in your ears? ☐NO ☐YES
    Comment: _____
16. Do you smoke? If answered yes, how often? ☐NO ☐YES
    Comment: _____
17. Do you have chronic pain in your muscles or joints? If answered yes, specifically where? ☐NO ☐YES
    Comment: _____

IF YOU ANSWER YES TO ANY OF THE ABOVE QUESTIONS, GIVE THIS FORM DIRECTLY TO YOUR DOCTOR, HE OR SHE CAN HELP!

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our offices.