



Tri-County Orthopaedic & Sports Medicine, P.A.
 160 Hanover Avenue • PO Box 1446 • Morristown, New Jersey 07962-1446
 Voice: (973) 538-2334 • Billing: (973) 538-0329
 Fax: (973) 829-9174 • RX Line: (973) 989-6317

Mark J. McBride, MD, FAAOS
 Robert T. Goldman, MD, FAAOS
 Wayne A. Colizza, MD, FAAOS
 Michael I. Goldberger, MD, FAAOS
 Paul M. Lombardi, MD, FAAOS
 Charles A. Gatto, MD, FAAOS
 Andrew A. Willis, MD
 Kenneth D. Montgomery, MD
 Claudia L. Ginsberg, MD
 Alena Polesin, MD
 Peter Tsairis, MD, FAAN

NAME _____ DATE _____ AGE _____

NEUROLOGICAL QUESTIONNAIRE

CIRCLE ONE

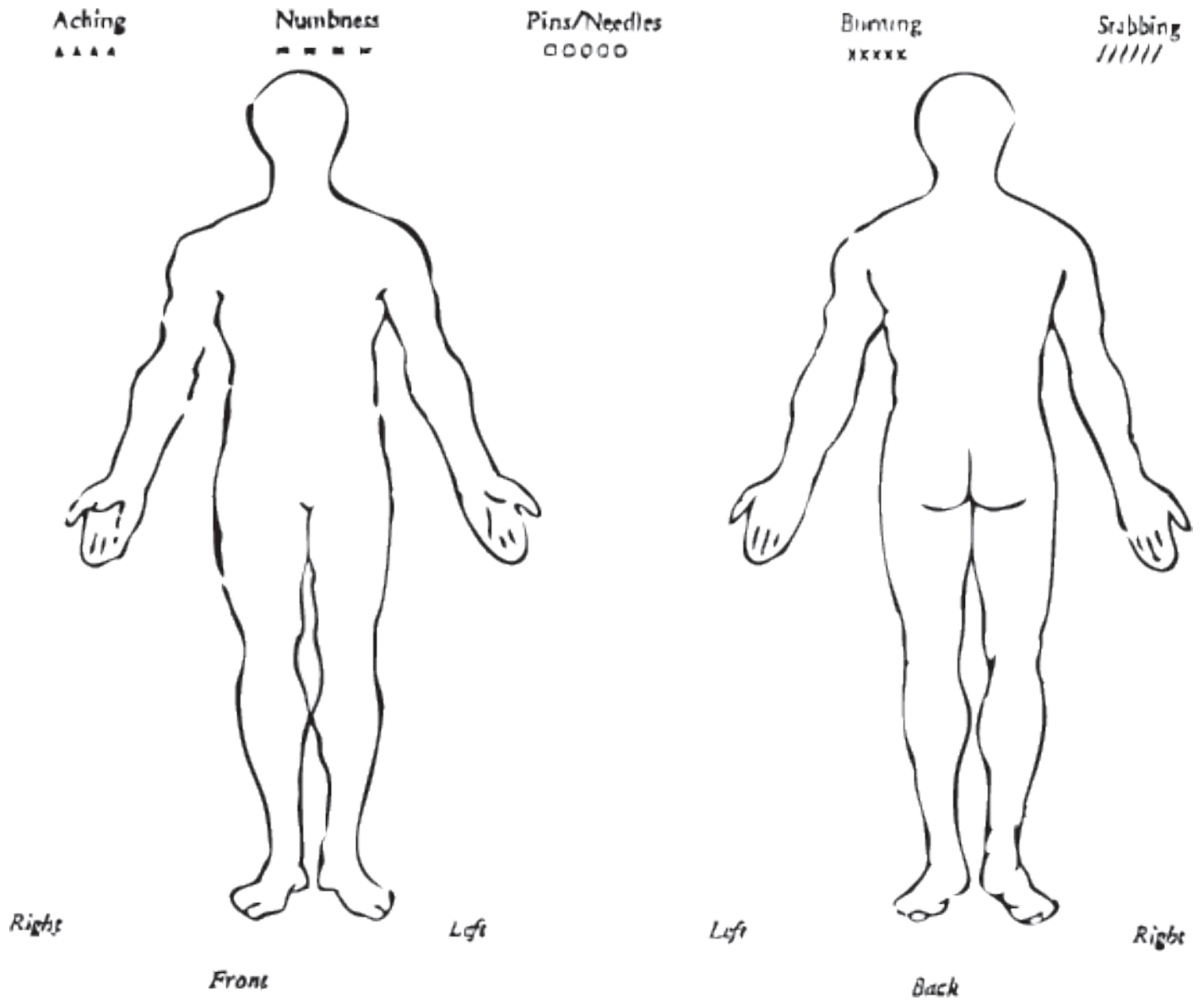
- | | | |
|---|-----|----|
| DO YOU SUFFER FROM TENSION OR MIGRAINE HEADACHES? | YES | NO |
| DO YOU HAVE PAIN AND/OR STIFFNESS IN YOUR NECK? | YES | NO |
| DO YOU HAVE LOW BACK PAIN? | YES | NO |
| HAVE YOU NOTICED ANY CHANGE IN YOUR EYESIGHT? | YES | NO |
| HAVE YOU EVER HAD SPOTS BEFORE YOUR EYES, DROOPY EYELIDS, BLURRING OF VISION, OR DOUBLE VISION? | YES | NO |
| HAVE YOU EVER HAD COMPLETE OR PARTIAL LOSS OF VISION IN ONE OR BOTH EYES? | YES | NO |
| HAVE YOU NOTICED ANY CHANGE IN YOUR HEARING? | YES | NO |
| HAVE YOU EVER HAD EARACHES OR RUNNING EARS? | YES | NO |
| DO YOU HAVE SINUS TROUBLE? | YES | NO |
| DO YOU HAVE NOSEBLEEDS? | YES | NO |
| HAVE YOU HAD ANY EPISODES OF LOSS OF SPEECH OR SLURRING? | YES | NO |
| DO YOU HAVE DIFFICULTY SWALLOWING OR CHEWING? | YES | NO |
| DO YOU SUFFER FROM NAUSEA OR VOMITING? | YES | NO |
| IS THERE ANY PROBLEM WITH YOUR SENSE OF SMELL AND/OR TASTE? | YES | NO |
| DO YOU LOSE YOUR BALANCE OR STAGGER? | YES | NO |
| DO YOU HAVE DIFFICULTY WALKING? | YES | NO |
| DO YOU HAVE SPELLS OF DIZZINESS OR VERTIGO? | YES | NO |
| HAVE YOU EVER FAINTED OR BLACKED OUT? | YES | NO |
| DO YOU HAVE EPILEPSY? | YES | NO |
| HAVE YOU EVER HAD A CONVULSION? | YES | NO |
| DO YOU SUFFER FROM UNCONTROLLABLE TENSION OR NERVOUSNESS? | YES | NO |

DO YOU HAVE DIFFICULTY GETTING TO SLEEP (INSOMNIA) OR A PROBLEM AWAKING IN THE MORNING?	YES	NO		
DO YOU EVER FEEL DROWSY OR SLEEPY?	YES	NO		
DO YOU HAVE AN EMOTIONAL DISORDER OR EVER BEEN UNDER THE CARE OF A PSYCHIATRIST?	YES	NO		
DO YOU HAVE TROUBLE WITH YOUR THINKING OR MEMORY ABILITY?	YES	NO		
HAVE YOU EVER LOST FEELING IN ANY PART OF YOUR BODY?	YES	NO		
HAS ANY PART OF YOUR BODY EVER BEEN PARALYZED?	YES	NO		
DO YOU HAVE NUMBNESS OR TINGLING IN YOUR HANDS OR FEET?	YES	NO		
DO YOU HAVE TROUBLE WITH COORDINATION?	YES	NO		
DO YOU HAVE MUSCLE PAIN, SORENESS, OR STIFFNESS?	YES	NO		
HAVE YOU NOTICED MUSCLE TWITCHING, SPASMS, OR CRAMPS?	YES	NO		
DO YOU FEEL OVERLY FATIGUED WITHOUT ENERGY?	YES	NO		
HAVE YOU NOTICED ANY RECENT CHANGE IN YOUR HANDWRITING?	YES	NO		
DO YOU GENERALLY FEEL CHILLY EVEN IN WARM WEATHER?	YES	NO		
HAVE YOU HAD ANY SPONTANEOUS EPISODES OF SWEATING?	YES	NO		
DO YOU HAVE ANY BIRTHMARKS?	YES	NO		
DO YOU HAVE DIFFICULTY WITH BOWEL OR BLADDER FUNCTION?	YES	NO		
DO YOU HAVE ANY SEXUAL DYSFUNCTION?	YES	NO		
HAVE YOU HAD ANY RECENT WEIGHT LOSS OR WEIGHT GAIN?	YES	NO		
DO YOU HAVE...				
MIGRAINE HEADACHES?	YES	NO	THYROID DISEASE?	YES NO
HIGH BLOOD PRESSURE?	YES	NO	ANEMIA?	YES NO
KIDNEY OR LIVER DISEASE?	YES	NO	HEART TROUBLE?	YES NO
DIABETES MELLITUS?	YES	NO	ARTHRITIS?	YES NO
SKIN RASH OR SKIN DISEASE?	YES	NO	FRACTURES?	YES NO
NECK OR LIMB TRAUMA?	YES	NO	TUMOR OR CANCER	YES NO
SYPHILIS OR OTHER VENEREAL DISEASE?				YES NO
ALLERGIES? YES NO PLEASE LIST:	_____			
OTHER?	_____			

PATIENT PAIN DRAWING

Name: _____ Date: _____

Where is your pain now?



Visual Analog Scale (VAS)

