

Parkinsons & Movement Disorders Center of Maryland – HEALTH QUESTIONNAIRE

NAME: _____

Date: ____/____/____

Reason for Visit: _____

C O N T R I B U T I O N	Family History	Deceased	Age	Mig-raine	High Blood Pressure	Diabetes	Heart Disease	Stroke	Seizures	Tremors	Parkin-son's	Other
	Mother											
	Father											
	Bro/Sis											
	Bro/Sis											
	Bro/Sis											
	Bro/Sis											
	Son/Daughter											
	Son/Daughter											

Year	Medical Conditions	Year	Surgeries

Allergies: _____

Medication	Strength	Times taken	Include non-prescription and "alternative" medications	Medication	Strength	Times taken	

Decreased hearing	Constipation	Cancer	Alcohol: # drinks per week:
Ringing in ear	Trouble swallowing	Weakness	Smoking: cig/day. # years:
Ear infections	Slurred speech	Numbness	Illicit Drugs
Dizziness	Trouble finding words	Tingling sensations	Coffee/tea/caffeinated drinks/day:
Lightheadedness	Poor comprehension	Back pain	FEMALES: Last Pap Test: _____
Fainting	Memory loss	Leg pain	Last Mammogram: _____
Blurred vision	Moodiness	Loss of urination	Birth Control?
Double vision	Nervousness	Urinary infections	List any other major concerns
Cataracts	Sleep problems	Falls	
Galucoma	Depression	Discoordination	
Impaired smell	Poor appetite	Slowed movement	
Nose bleeds	Weight loss – recent	Shuffling walking	
Impaired taste	Chronic fatigue	Tremors	
Pneumona	High blood pressure	Stiffness	
Asthma/COPD	Heart palpitations	Seizures	
Shortness of breath	Irregular pulse	Herpes	
Chest pain	Swollen ankles	Lyme Disease	

Diarrhea	Diabetes		
----------	----------	--	--