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MOVEMENT DISORDERS

Today's Date

Last Name First MI

Date of Birth Age

GENERAL PATIENT INFORMATION

You must complete or already have on file the ***patient medical history short form*** or ***long form***.
Please make sure that all of the information on your medical history form is updated including phone numbers, addresses and insurance information.
Answer the following questions and bring the answers to your appointment. There is room at the end of each section for additional comments. Please give necessary details for "yes" answers.

PRESENT ILLNESS – MOVEMENT DISORDERS

HPI:

1. Date Parkinson's diagnosed:

2. Sinemet responsive: ☐ Yes ☐ No 3. Duration of Sinemet responsive: (hrs)

4. Parkinson symptoms:

Tremor ☐ RUE ☐ LUE ☐ Both ☐ RLE ☐ LLE ☐ Both

Rigidity	☐ Yes	☐ No	Balance Difficulties	☐ Yes	☐ No
Bradykenesia	☐ Yes	☐ No	On/Off	☐ Yes	☐ No
Dyskenesias	☐ Yes	☐ No	Drooling	☐ Yes	☐ No
Micrographia	☐ Yes	☐ No	Memory disturbance	☐ Yes	☐ No
Hallucinations	☐ Yes	☐ No	Orthostatic hypotension	☐ Yes	☐ No
Sex dysfunction	☐ Yes	☐ No	Incontinence	☐ Yes	☐ No

Other:

Main Parkinsonian problems not well controlled by medication:

MOVEMENT DISORDERS SECTION

TREMORS - Section 1

Do you have tremors? ☐ Yes ☐ No

Which part of the body is mainly involved? ☐ Head/face ☐ Hands ☐ Legs

Does tremor disappear during ☐ active movements or ☐ sleep?

Do you have rigidity or stiffness? ☐ Yes ☐ No

Which part of the body is involved? ☐ Head/face ☐ Hands ☐ Legs

Do you have any of the following movement or gait/walking difficulties?

☐ Yes ☐ No Slowing of movements

☐ Yes ☐ No Clumsiness

☐ Yes ☐ No Difficulties to start or stop walking (bumping into walls or objects)

☐ Yes ☐ No Difficulties in turning around (causing loss of balance and falling)

☐ Yes ☐ No Walking in small steps

☐ Yes ☐ No Stooped posture when walking

☐ Yes ☐ No Shuffling gait

Do you have any other symptoms listed below?

☐ Yes ☐ No Increased sweating ☐ Yes ☐ No Drooling

☐ Yes ☐ No Changes in writing: small-size handwriting

☐ Yes ☐ No Speech difficulties, soft voice ☐ Yes ☐ No Fatigue

☐ Yes ☐ No Memory problems ☐ Yes ☐ No Emotional swings

☐ Yes ☐ No Depression ☐ Yes ☐ No Sexual dysfunction

CRAMPS OR TWISTING MOVEMENTS - Section 2

Do you have cramps or twisting movements of any part of the body? ☐ Yes ☐ No

☐ Eyes ☐ Neck ☐ Hands/legs ☐ Whole body

Have you noticed any unusual grimacing or tongue/mouth movements? ☐ Yes ☐ No

Is the cramp/twisting triggered by any activity? ☐ Yes ☐ No

Does the touching of the affected area decrease the cramp? ☐ Yes ☐ No

Is the cramp associated with pain? ☐ Yes ☐ No

Has the cramp/twisting progressed to involve other parts of the body? ☐ Yes ☐ No

What do you think started this disorder? ☐ Trauma ☐ Drugs ☐ Toxins

Did you have Botox (botulinum toxin) treatment? ☐ Yes ☐ No

Did the treatment help you and for how long? ☐ Yes ☐ No

UNUSAL MOVEMENTS - Section 3.

Do you have any unusual type of movements? ☐ Yes ☐ No Describe

Do you have any brief, sudden movements, frequently repetitive and stereotypic as listed:

☐ Blinking ☐ Head jerking or shaking ☐ Nose twitching

☐ Jumping ☐ Kicking ☐ Hitting

☐ Throwing ☐ Touching

Can you control them? ☐ Yes ☐ No If YES, how long?

Are you aware of any unusual noises that you make? ☐ Yes ☐ No

☐ Throat clearing ☐ Coughing ☐ Grunting

☐ Sneezing ☐ Squeaking ☐ Screaming

Do you feel urge to say obscene words? ☐ Yes ☐ No

Do you have brief, sudden shock-like jerks? ☐ Yes ☐ No

Do you have involuntary, continuous dance-like movements? ☐ Yes ☐ No

Do they interfere with your daily activities? ☐ Yes ☐ No

Did you notice any new memory problems? ☐ Yes ☐ No

Do you have some difficulties in control your emotions? ☐ Yes ☐ No

Do you think you are compulsive? ☐ Yes ☐ No If so, why?

Do you think you are hyperactive? ☐ Yes ☐ No If so, why?

STROKE - Section 4.

Have you been diagnosed with stroke or mini-stroke (TIA - transient ischemic attack)? ☐ Yes ☐ No

Have you had any of the following symptoms?

☐ Weakness or paralysis of any part of the body ☐ Decreased fine motor skills

☐ Difficulties with coordination ☐ Walking problems

☐ Tingling or numbness of any part of the body ☐ Slurred speech or lack of speech

☐ Speech problems, such as difficulties word finding, misnaming objects

☐ Hoarseness ☐ Difficulties in swallowing

☐ Double or blurred vision ☐ Transient blindness

☐ Visual field defects (difficulty with peripheral vision, loss of vision in any segment)

☐ Dizziness or spinning accompanied by nausea and vomiting

☐ Mental status changes

Were these symptoms ☐ Transient or ☐ Permanent?

Have you had tPA or heparin as a treatment for the stroke? ☐ Yes ☐ No

Are you currently taking any of the following?

☐ Aspirin ☐ Plavix/Clopidogrel ☐ Ticlid

☐ Coumadin/Warfarin ☐ Aggrenox ☐ Dipyridamole/Persantine

WALKING AND BALANCE - Section 5. (Circle below if applicable)

Do you have walking and balance problems? ☐ Yes ☐ No

☐ Diminished coordination in athletics or extraordinary activities

☐ Occasional stumbling or slipping in everyday activities but no device needed

☐ Frequent falls unless a straight cane is used

☐ Frequent falls unless a walker or fixed supporting object is used

☐ Confined to wheelchair

CLUMSINESS OF HANDS - Section 6.

Do you have clumsiness of your hands? ☐ Yes ☐ No (If tremor is constant, skip this section)

☐ Only when performing unusually demanding activities or minor change in handwriting

☐ Occasional fumbling with ordinary activities but no practical disability

☐ Frequent fumbling causing difficulty with eating, dressing, writing or working, but you still do these things routinely

☐ Severe fumbling causing many tasks to be avoided entirely; barely legible or illegible handwriting; inability to eat in public; dressing

☐ Hands are essentially useless

SHAKING OF HANDS - Section 7.

Do you have rhythmic shaking of hands? ☐ Yes ☐ No If YES, check the following:

☐ On certain rare occasions or in some positions a temporary tremor occurs

☐ In everyday activities, a mild tremor occurs at times which does not interfere with any of my daily activities

☐ In everyday activities, a tremor occurs which produces some interference with the activity (e.g. handwriting corrupted, coffee spilled, items dropped, etc.)

☐ A tremor is frequently present which is so severe that certain routine activities using that part of the body are avoided entirely

☐ Very severe tremor which often renders the part of the body essentially unusable

SPEECH - Section 8.

Do you have speech problems? ☐ Yes ☐ No check below if applicable:

☐ Occasional slurring or jumbling when speaking very rapidly or under pressure

☐ Occasional slurring during ordinary speaking but speech is fully understood

☐ Frequent slurring or jumbling such that speech is sometimes not understood

☐ Severe slurring or jumbling ordinary speaking such that speech is very often not understood

☐ Swallowing difficulties

VISION - Section 9.

Do you have vision problems? ☐ Yes ☐ No check below if applicable

☐ Occasional difficulty focusing or fixating when under stress or looking at rapidly changing images

☐ Occasional difficulty fixating or focusing in everyday situations

☐ Cannot read but otherwise vision good enough to use in everyday life

☐ Severe problems with focusing or moving image frequently during the day that interferes with many different activities

☐ Focusing or fixation difficulties so great that there are always problems seeing everything

FATIGUE - Section 10.

Do you have problems with fatigue? ☐ Yes ☐ No check below if applicable:

☐ Exercise tolerance not as great as before, but everyday activities do not produce unusual fatigue

☐ Everyday activities cause more fatigue but daily routine not really changed

☐ Daily activities cause enough fatigue to cause daily schedule to be changed or strenuous activities such as yard work or heavy cleaning have been eliminated

☐ Daily activities cause severe fatigue such that some everyday activities such as cooking, washing dishes or house-cleaning have been eliminated

☐ Essentially confined to movement from bed to chair and no occupational or household activities are accomplished

WORK PROBLEMS - Section 11.

How has your job or work activity been affected by your movement disorder?

- ☐ I have never been able to work
- ☐ I have only been able to work part-time
- ☐ It has interfered with or caused me to miss work
- ☐ I changed jobs because of the movement disorder
- ☐ I lost jobs because of the movement disorder
- ☐ No change has occurred due to the movement disorder
- ☐ I had already stopped working by the time the disorder started
- ☐ Other:

What kind of diagnosis did you have for your movement disorder?

Did or does any of your blood relatives have similar problems? ☐ Yes ☐ No

MEDICATIONS

What are your current medications, include hormones, birth control pills, vitamins, etc. (Name and amount/day)?

Medication	Amount	Medication	Amount
1		6	
2		7	
3		8	
4		9	
5		10	

Are you taking oral contraceptive pills? ☐ Yes ☐ No If YES, how long?

Do you take any herbal supplements? ☐ Yes ☐ No

Do you have a diet that includes fruit, vegetables, meat, milk and grains? ☐ Yes ☐ No

I not, please indicate any categories from which you rarely eat:

BIRTH HISTORY

Was your mother's pregnancy with you abnormal? ☐ Yes ☐ No

Was the labor and delivery abnormal (pre/post term complications? ☐ Yes ☐ No

Were there any problems immediately after birth, during infancy or childhood? ☐ Yes ☐ No

High fevers ☐ Yes ☐ No Meningitis or encephalitis ☐ Yes ☐ No

Severe neck or head injury ☐ Yes ☐ No Seizures or epilepsy ☐ Yes ☐ No

Stroke ☐ Yes ☐ No

DEVELOPMENTAL HISTORY

Did you have difficulty learning to walk? ☐ Yes ☐ No

How old were you when you took your first steps?

Did you have bodily deformity or abnormal curvature? ☐ Yes ☐ No

Did you have any clumsiness, paralysis or weakness? ☐ Yes ☐ No

Did you have difficulty learning to talk? ☐ Yes ☐ No

How old were you when you began to speak?

Did you have difficulty with concentration or behavior in school? ☐ Yes ☐ No

Did you have any areas of learning or reading disability? ☐ Yes ☐ No

Are you ☐ Right handed ☐ Left handed ☐ Both

Do you write with your ☐ Right hand ☐ Left hand ☐ Both

Do you eat with your ☐ Right hand ☐ Left hand ☐ Both

Do you throw with your ☐ Right hand ☐ Left hand ☐ Both

If right-handed, were you naturally left-handed (trained to use R instead of L)? ☐ Yes ☐ No

Do you have an allergy or a sensitivity to any medication? ☐ Yes ☐ No

PAST MEDICAL HISTORY, REVIEW OF SYSTEMS

Check health issues you currently have or have had in the past:

General Health Problems

☐ Abdominal Pain	☐ Back Pain	☐ Blurred vision
☐ Change in vision	☐ Chest pain	☐ Constipation
☐ Diarrhea	☐ Diabetes	☐ Dizziness
☐ Double vision	☐ Easy fatigue	☐ Headaches
☐ Hearing problems	☐ Heart problems	☐ High cholesterol
☐ High or low blood pressure	☐ Leg swelling	☐ Loss of appetite
☐ Loss of vision	☐ Migraine or other headaches	☐ Muscle cramps
☐ Muscle wasting	☐ Nausea	☐ Neck Pain
☐ Palpitations (abnormal or fast beating of the heart)		☐ Pain in back of jaw (TMJ)

☐ Shortness of breath ☐ Stomach Pain ☐ Vomiting

☐ Weakness ☐ Weight gain/loss

☐ Other pain, location or type:

Psychological Problems

☐ Treatment by a psychiatrist or counselor ☐ Depression or unusual amounts of stress

☐ Panic Attacks

Lungs

☐ Breathing problems ☐ Cough productive/non-productive ☐ Sputum color

Urinary

☐ Frequency increased/decreased ☐ Burning/painful urination

☐ Blood in urine ☐ Urinary incontinence

Musculo-skeletal

☐ Pain during movements ☐ Decreased range of movements

☐ Swelling of joints ☐ Fractures

Sleep difficulties:

Describe:

Mood disorders:

☐ Apathy (lack of interests) ☐ Depression ☐ Sexual difficulties

Cancer

☐ What type: ☐ 15 lb or more weight loss

Systemic Diseases

☐ AIDS

Metabolic Problems

☐ Arthritis ☐ Kidney problems

☐ Blood diseases, anemia ☐ Dialysis

☐ Liver disease ☐ Fevers or swollen glands

☐ Low sugar (hypoglycemia) ☐ Skin diseases

☐ Thyroid disorders ☐ Lupus

☐ Syphilis or venereal disease ☐ Mononucleosis (Epstein Barr)

☐ Lyme disease ☐ Meningitis

☐ Tuberculosis (TB)

Eye Problems

☐ Crossed eyes, lazy eye ☐ Poor vision in one eye (amblyopia)

Neurological Problems

☐ Bladder problems ☐ Tremor or incoordination

☐ Problems with sexual function ☐ Trouble speaking

☐ Loss of consciousness (faints or seizures)

☐ Pins and needles, numbness (where)

☐ Muscle weakness (where)

Surgeries

☐ Appendix ☐ Breast ☐ Cataract ☐ Carotid

☐ C-Section ☐ Ear ☐ Gall Bladder ☐ Hysterectomy

☐ Prostate ☐ Sinus ☐ Stomach ☐ Tonsils

☐ Other:

LIFE STYLE - HABITS

Educational level completed:

☐ Grade school ☐ High school ☐ College ☐ Post graduate

Are you currently receiving disability? ☐ Yes ☐ No If YES, how long?

Living arrangements:

☐ Live alone ☐ With spouse or roommate ☐ With parents ☐ Other:

Have you ever had a car accident? ☐ Yes ☐ No

If YES, please explain:

How many alcoholic drinks per week ? ☐ None ☐

Do you smoke cigarettes, cigars or pipes ? ☐ No ☐ Yes

How many caffeinated drinks per day? ☐ None ☐ More than 4

Do you have regular sleep/wake patterns ? ☐ No ☐ Yes

Do you salt your food? ☐ No ☐ Moderate ☐ Lots

Are you currently involved in litigation with respect to any medical problems ? ☐ No ☐ Yes

Are you usually highly stressed? ☐ No ☐ Yes

Do you usually eat 3 meals/day? ☐ No ☐ Yes

INJURIES (Check and date)

☐ Head date

☐ Neck (for example whiplash) date

☐ Dental work date

EXPOSURES OR INFECTIONS: (Check and date)

☐ Exposure to poisons (food, chemical) date

☐ Chemicals (pesticides, industrial solvents) date

☐ Infections (AIDS, syphilis, gonorrhea) date

☐ Carbon Monoxide (car or house) date

☐ Tuberculosis or Cysticercosis date

☐ History of meningitis date

FAMILY HISTORY

Are there any **family members** with:

☐ Stroke ☐ Diabetes

☐ Seizures ☐ Heart disease or high blood pressure

☐ Migraine headaches

☐ Other diseases that run in the family (list)

GENERAL MEDICAL TESTS

☐ Recent general medical checkup? Date:

☐ Recent blood tests (Glucose, blood count) Date:

☐ Heart test (EKG, Stress test, Holter Monitor) Date:

ADDITIONAL TESTS AND PROCEDURES

Have you ever had any of the following studies done? Check if applicable:

☐ CT brain/spine	☐ MRI brain/spine	☐ EEG
☐ EMG/nerve condition study	☐ LP – lumbar puncture	☐ Carotid Doppler
☐ ECHO	☐ Genetic studies	

SLEEP PROBLEMS – THE EPWORTH SLEEPINESS SCALE

How likely are you to *doze off or fall asleep,* in contrast to just feeling tired, in the following situations? This refers to your usual way of life in recent times. Even if you have not done a particular activity recently, try to work out how they would have affected you. Check your chance of dozing or falling asleep as: would never doze, slight chance of dozing, moderate chance of dozing, high chance of dozing or falling asleep.

Sitting and reading	☐ 0-Never	☐ 1-Slight	☐ 2-Moderate	☐ 3-High
Watching television	☐ 0-Never	☐ 1-Slight	☐ 2-Moderate	☐ 3-High
Sitting inactive in a public place (e.g. theater)	☐ 0-Never	☐ 1-Slight	☐ 2-Moderate	☐ 3-High
As a passenger in a car for an hour	☐ 0-Never	☐ 1-Slight	☐ 2-Moderate	☐ 3-High
Lying down to rest in the afternoon	☐ 0-Never	☐ 1-Slight	☐ 2-Moderate	☐ 3-High
Sitting and talking to someone	☐ 0-Never	☐ 1-Slight	☐ 2-Moderate	☐ 3-High
Sitting quietly after lunch without alcohol	☐ 0-Never	☐ 1-Slight	☐ 2-Moderate	☐ 3-High
In a car, stopped in traffic	☐ 0-Never	☐ 1-Slight	☐ 2-Moderate	☐ 3-High

Total points:

Answer the following as: Never, Sometimes, Often, Always

Do you fall asleep or get sleepy when driving?	☐ 0-Never	☐ 1-Some	☐ 2-Often	☐ 3-Always
Do you fall asleep or get sleepy when at work?	☐ 0-Never	☐ 1-Some	☐ 2-Often	☐ 3-Always
Do you take intentional naps?	☐ 0-Never	☐ 1-Some	☐ 2-Often	☐ 3-Always
Do you experience short periods of muscle weakness or loss of muscle control (especially with laughter or excitement)?	☐ 0-Never	☐ 1-Some	☐ 2-Often	☐ 3-Always
Do you experience vivid dreamlike episodes when falling asleep?	☐ 0-Never	☐ 1-Some	☐ 2-Often	☐ 3-Always
Do you feel unable to move (paralyzed) when falling asleep?	☐ 0-Never	☐ 1-Some	☐ 2-Often	☐ 3-Always
Do you ever experience an uncomfortable or restless sensation in your legs when you relax or are first going to sleep, that is relieved by moving or getting out of bed and walking?	☐ 0-Never	☐ 1-Some	☐ 2-Often	☐ 3-Always

Please obtain copies of all relevant reports and CT/MRI films. Bring these reports to your appointment.

Note: The physician who referred you to us will receive a copy of your medical report.

Please allow 2 to 3 weeks for your physician to receive our report. If you would like to request a copy of our report from us, please contact us at 262-631-8550