Joseph Jankovic, M.D.
Professor of Neurology
Distinguished Chair in Movement Disorders
Director, Parkinson's Disease Center
and Movement Disorders Clinic

Joohi Jimenez-Shahed, M.D.
Assistant Professor of Neurology

Mary Ann Thenganatt, M.D.
Assistant Professor of Neurology

Joshua Shulman, M.D., Ph.D.
Assistant Professor of Neurology

Department of Neurology
Parkinson's Disease Center
and Movement Disorders Clinic
6550 Fannin, Suite 1801
Houston, TX 77030
www.bcm.edu
www.jankovic.org
Phone: 713-798-7438
Fax: 713-798-6808

NEW PATIENT QUESTIONNAIRE
PLEASE FILL OUT COMPLETELY: USE "N/A" IF NOT APPLICABLE

Today's Date (mm/dd/yyyy): ___ / ___ / _____ Date of Birth: ___ / ___ / _____

NAME: Last_____, First _____, Middle Initial_____

Home Address:_____
_____
_____
Emergency Contact Name _____

Home Phone # (____)_____
Work/Cell Phone#:_(_____)_____
Contact # (_____)_____

Name and Address of Referring Physician:
_____
_____
_____
Phone#:_(____)_____
FAX#:_(____)_____

Name and Address of Primary Care Physician:
_____
_____
_____
Phone#:_(____)_____
FAX#:_(____)_____

Handedness (circle one): Right Left Ambidextrous

Marital status: (circle one) S M D W

How many years of school have you completed? _____

Occupation: _____

How Long? _____

Current Status FT ___PT ____Retired ___Disabled __
Student ___ Unemployed _____

What is the reason for your office visit? _____
_____

List **Any Allergies** to Medications (Name of drug and reaction)**:**
_____
_____
_____

List **ALL** Surgical Procedures done: (Type and date):
_____
_____
_____
_____

PAST MEDICAL HISTORY: _____
_____
_____
_____

Please circle below any tests you have had for your current condition:

MRI SPINE MRI BRAIN CT SCAN BRAIN OTHER IMAGING _____

EMG/NERVE CONDUCTION STUDIES EEG (Electroencephalogram)

SLEEP STUDIES

Genetic testing? Yes / No Any special lab test for this condition? Yes / No If yes please list: _____

➔ TURN OVER AND COMPLETE THE BACK PAGE ←

Please list **ALL** medications you are currently taking (attach a separate page if needed and include herbals/nutritional supplements and over-the-counter medications):

Name of medication	Dose	Frequency	Reason for taking	Taken for how long?
1				
2				
3				
4				
5				
6				
7				

Relative	Age or Age at death	Deceased?	Medical and/or Neurologic Condition(s)
Mother			
Father			
Sisters			
Brothers			
Sons			
Daughters			
Others			

Please Circle any Condition(s) That Apply To You Within The Last Eight Weeks:

GENERAL: fever, weight gain/loss, fatigue, other_____

EYES: vision loss, blurry vision, double vision, other:_____

EAR/NOSE/THROAT: loss of smell, hearing loss, voice changes, other:_____

CARDIAC: chest pains, palpitations, irregular heartbeat, lightheadedness, other: _____

RESPIRATORY: shortness of breath, cough, asthma, other:_____

GI: ulcers, reflux, nausea/vomiting, diarrhea, constipation, other: _____

GU: losing control of bladder, increased urinary frequency, increased urgency urgency, sexual dysfunction, post-menopausal, surgically sterile, other _____

BLOOD: anemia, easy bruising, bleeding or clotting disorder, other:_____

MUSCULOSKELETAL: joint swelling, joint pain, arthritis, muscle aches, ankle swelling, other:_____

ENDOCRINE: heat or cold intolerance, losing hair, diabetes, thyroid problems, other: _____

SKIN: rashes, suspicious lesions, change in skin color, other: _____

PSYCHIATRIC: hallucinations, delusions, memory loss, depression, anxiety, bipolar, OCD, ADD, ADHD, other: _____

NEUROLOGIC: tremor, stiffness, gait imbalance, numbness, tingling, headaches, seizures, strokes, other: _____

_____

SLEEP: can't get to sleep, can't stay asleep, restless legs, acting out dreams, sleep apnea, other:_____

Social History:

Tobacco Use: Cigarettes: Yes / No Cigars: Yes / No Pipe: yes / no Smokeless (Chew/Snuff): Yes / No

If yes, what quantity? _____/day How long? _____ Prior Smoker: Yes / No How long? _____

Alcohol Use: (circle all that apply): Beer Wine Liquor Hooch Caffeine use: Yes / No

If yes, amount per week_____ If yes, amount per week_____

Other: Do you use recreational or intravenous drugs? Yes / No

If yes, please list: _____

PLEASE MAKE SURE YOU HAVE COMPLETED THE FRONT OF THIS FORM ←