NEW JERSEY
BRAIN AND SPINE

Elana Clar, MD
Board Certified Neurologist
Movement Disorders Specialist

Movement Disorders New Patient Questionnaire

Please email your completed form to rociom@NJbrainspine.com AT LEAST 1 week before your scheduled appointment

Name _____ **Date of Birth**_____

Age _____ **Sex** _____ **Social Security** _____

Address _____

Mobile Phone _____ **Home Phone** _____

Email Address(es) _____

Emergency Contact Name _____ **Relationship** _____

Emergency Contact Number(s) _____

Referring Patient or Physician _____

Address _____

Phone Number(s) _____

Do you wish us to send a consultation note to your referring physician? **Yes** ◯ **No** ◯

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Pharmacy Name _____ **Pharmacy Number**_____

Pharmacy Address _____

HISTORY OF PRESENT ILLNESS

Please explain the main reason(s) you are seeking a movement disorders consultation:

1) _____
2) _____
3) _____

Reconstruct, as best as possible, the story of your illness. Include the first symptoms you or others noticed. What happened next? Did you have further progression of your symptoms? Did this occur acutely or gradually? Are there certain things prior to your illness you used to do easily but can no longer do now?

_____

_____

_____

_____

_____

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_____

_____

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_____

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_____

Are you interested in Deep Brain Stimulation (DBS)? **YES** ◯ **NO** ◯

Please list any health care providers you have previously seen for this issue:

Date	Provider Name	Provider Specialty	Treatment Provided (if any)

_____

_____

_____

_____

680 Kinderkamack Road, Suite 300 Oradell, NJ 07649 | 20 Prospect Avenue, Suite 907 Hackensack, NJ 07601
Phone: 201.342.2550 | Fax: 201.342.7171 | www.njbrainspine.com

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Have you ever had one of the following tests? If so, please provide brief details:

	Date	Where Obtained?	Result?
CT of Head			
CT of Spine			
MRI of Brain			
MRI of Spine			
EEG			
EMG/NCS			
Spinal Tap			
Other			

Do you have any drug allergies? Yes ◯ **No** ◯

If yes, please list the drug and what allergic reaction you get:

_____

_____

_____

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List all your CURRENT MEDICATIONS:

Name of Medication	Dose (mg)	Number of Times a Day (list times if necessary)

List all your PRIOR MEDICATIONS tried for this particular illness:

Name of Medication	Dose (mg)	Number of Times a Day

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PAST MEDICAL/SURGICAL HISTORY

Please list any of your chronic medical conditions (even if you are not on medications for it) and any prior surgeries/hospitalizations (with the date):

_____

_____

_____

_____

_____

_____

_____

_____

_____

PERSONAL HISTORY

Are you right-handed or left-handed? _____

Current height: _____ **Current weight:** _____

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Are you presently employed?_____ Present/Former Occupation: _____

Marital Status (Please Circle): Single / Married / Divorced / Widowed

How many children do you have? _____

Who currently lives with you at home? _____

SOCIAL HISTORY

Do you get any exercise on a regular basis? _____ If so, what do you like to do? _____

_____

SMOKING HISTORY (IF YOU HAVE NEVER SMOKED, PLACE "0" IN ALL THE ANSWERS):

Year Stopped: _____ Number of Packs/Day _____ Number of Years Smoked: _____

DRINKING HISTORY (IF YOU DO NOT DRINK, PLACE A "0" IN THE BLANK):

Number of beers or glasses of wine per week: _____

RECREATIONAL DRUG HISTORY (IF YOU HAVE NEVER TRIED DRUGS, PLACE "0" IN ALL THE ANSWERS):

Marijuana _____ Cocaine _____ Heroin _____ Other _____

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FAMILY MEDICAL HISTORY

	If Alive, Current Age	If Alive, List Medical Issues	If Dead, Age at Death	Medical History or Cause of Death
Mother				
Father				
Brother				
Sister				
Other Sibling				
Son				
Daughter				
Other Child				

Is there any other information that you would like to share for the purposes of this consultation?

_____

_____

*****PLEASE OBTAIN ANY PERTINENT MEDICAL RECORDS (INCLUDING PHYSICIAN NOTES, IMAGING REPORTS, IMAGING DISCS AND BLOODWORK) OVER THE PAST YEAR, AND BRING THIS TO YOUR 1ST APPOINTMENT*****