

**Neuro-ophthalmology New Patient Questionnaire**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Race: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_

Do you have or have you had any significant medical illnesses? If so, please list all of them:

---

---

---

---

---

---

---

Please list all prior major surgeries, with dates of operation: \_\_\_\_\_

---

---

---

Please list your current prescription medications; including dose and how often you are taking them. Also include any eye medications or aspirin you may be taking:

---

---

---

---

Please list all drug allergies: \_\_\_\_\_

Please list all prior eye problems or eye surgeries: \_\_\_\_\_

---

Have you smoked? Y N Total # yrs \_\_\_\_\_ Average # of packs/day \_\_\_\_\_

Have you consumed alcohol? Y N Total # yrs \_\_\_\_\_ Average #/week \_\_\_\_\_

Are there any medical problems that run in your family? If so, please describe illness and list the family members affected:

---

Have you ever been diagnosed or treated for any of the following conditions? (circle all that apply)

- |                                 |                                    |
|---------------------------------|------------------------------------|
| High blood pressure             | Neuropathy                         |
| Diabetes; Non insulin dependent | Migraine                           |
| Diabetes; Insulin dependent     | Meningitis                         |
| Brain tumor                     | Syphillis                          |
| Epilepsy                        | Sarcoidosis                        |
| Hypothyroidism                  | Lyme disease                       |
| Hyperthyroidism                 | Cat-scratch fever                  |
| Myasthenia Gravis               | Myopathy                           |
| Grave's Disease                 | Multiple Sclerosis                 |
| Stroke or TIA                   | Alcoholism                         |
| Parkinson's Disease             | Lupus                              |
| Horner's Syndrome               | Coagulation or Clotting Disorder   |
| Bell's Palsy                    | Hydrocephalus/"water on the brain" |
| Amblyopia or Lazy Eye           | Heart disease                      |
| Cataract                        | HIV or AID's                       |
| Glaucoma                        | Herpes                             |
| Optic Neuritis                  | Temporal arteritis                 |
| Head trauma                     | Pseudotumor Cerebri                |
| Trigeminal Neuralgia            | Blepharospasm                      |
| Hemifacial spasm                | Retinitis Pigmentosa               |

**Review of Systems: (Circle all which apply)**

**Have you recently had:**

- |   |   |   |
|---|---|---|
| 1. Lightheadedness                          | Y | N |
| 2. Nausea or vomiting                       | Y | N |
| 3. Loss of consciousness                    | Y | N |
| 4. Seizures                                 | Y | N |
| 5. Vertigo                                  | Y | N |
| 6. Numbness                                 | Y | N |
| 7. Tingling                                 | Y | N |
| 8. Fatigue/Lethargy                         | Y | N |
| 9. Muscle weakness                          | Y | N |
| 10. Muscle aches                            | Y | N |
| 11. Balance difficulty/loss of coordination | Y | N |
| 12. Temporary blindness                     | Y | N |
| 13. Ringing in the ears                     | Y | N |
| 14. Scalp tenderness                        | Y | N |
| 15. Fever                                   | Y | N |
| 16. Neck pain                               | Y | N |
| 17. Difficulty swallowing                   | Y | N |
| 18. Difficulty speaking                     | Y | N |
| 19. Pain with chewing                       | Y | N |
| 20. Poor color vision                       | Y | N |
| 21. Eye pain or discomfort                  | Y | N |
| <u>If yes</u> , with eye movement only?     | Y | N |
| 22. Drooping of one or both eyelids         | Y | N |
| 23. Patterns of light in your vision        | Y | N |
| 24. Facial pain                             | Y | N |
| 25. Blurred vision                          | Y | N |

(If yes, circle one reply on each line)

Is the blurred vision:

Does it affect:

Does it occur at:

Fluctuating      or      Constant  
 Right eye      Left eye      Both eyes  
 Near (reading)      or      Distance      or      Both

26. Loss of vision Y N  
 (If yes, circle one reply on each line)

<u>Is the loss of vision:</u>	Fluctuating	<u>or</u>	Constant
<u>Does it affect:</u>	Right eye	Left eye	Both eyes
<u>Does it occur at:</u>	Near (reading)	<u>or</u> Distance	<u>or</u> Both

27. Blind spots in your vision Y N  
 (If yes, circle one reply)

Do the blind spots affect: Right eye Left eye Both eyes

28. Double vision Y N  
 (If yes, select the appropriate responses below)

<u>Is the Double vision:</u>	Fluctuating	<u>or</u>	Constant
<u>Does it go away when one eye is covered or closed?</u>			Y N

<u>Are the two objects seen double:</u>	Side-by-side	Y	N
	One on top of the other	Y	N
	Diagonal to each other	Y	N

Is Double vision worse looking in any one particular direction? Y N

If so, which direction?: Right Left Up Down

29. Headache Y N

If yes, is it a:

Throbbing/pulsating sensation?	Y	N
Squeezing/pressure-like feeling?	Y	N
Aching sensation?	Y	N

How often do you get the headache? \_\_\_\_\_

How long does the typical headache last? \_\_\_\_\_

Is there associated nausea or vomiting? \_\_\_\_\_

Are you light-sensitive during the headache? Y N

Are you noise-sensitive during the headache? Y N

Is there associated tenderness of your scalp? Y N

What triggers the headache? \_\_\_\_\_

What makes the headache feel better? \_\_\_\_\_

How severe is the headache (on a scale of 1 to 10)? \_\_\_\_\_