

Colorado Institute for Neuromuscular and Neurological Disorders
Initial Visit Questionnaire

Date: _____

Patient Name: _____ Date of birth: _____ Referred by: _____

CHIEF COMPLAINT: Please describe in your own words the reason for your appointment.

Which hand do you write with? Right Left

PAST MEDICAL HISTORY: (List all current and prior medical problems, including any problems that are controlled on your current medications)

PAST SURGICAL HISTORY: (List all current and prior surgical problems)

FAMILY HISTORY: (List any significant medical problems of your closest relatives - grandparents, parents, siblings, children)

SOCIAL HISTORY:

Marital status: _____

Do you live alone? Yes No

Children: _____

Educational level: _____ Occupation: _____

Are you currently smoking? Yes No

If yes, how much do you smoke per day? _____

How long have you been smoking? _____

If no, have you ever smoked tobacco? Yes No

If yes, when did you quit and how much did you smoke before then?

Colorado Institute for Neuromuscular and Neurological Disorders

Initial Visit Questionnaire

Do you drink alcohol? Yes No

If yes, how much do you drink per day or week? less than 2 drinks per day
 more than 2 drinks per day

If more than 2 drinks per day, how much do you drink? _____

If no, have you ever drunk more than 2 drinks per day? Yes No

If yes, when did you start drinking less than 2 drinks per day and how much did you drink before then? _____

Do you use street/illegal/recreational drugs? Yes No

If yes, which drugs do you currently use? _____

If no, have you ever used street/illegal/recreational drugs? Yes No

If yes, which drugs did you use and when is the last time you used them?

ALLERGIES: (Please list any allergies to medications or other substances)

MEDICATIONS: (Please list all of your current medications. Include the name, strength (i.e. 325 mg), and how you take the medication (i.e. 1 pill three times per day.) Please continue on the reverse side of this form if needed.

Name of Medication	Strength	How taken

X _____

Patient (or responsible party)

DATE