Colorado Institute for Neuromuscular and Neurological Disorders
Initial Visit Questionnaire

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 with your current medications.

_____

_____

PAST SURGICAL HISTORY List all current and prior surgical procedures.

_____

_____

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 If not, whom do you live with? _____

If you have children, how many? _____

Last grade you completed in school: _____

Occupation: _____

Do you currently drink alcohol? __ Yes __ No

If **yes**:
How much do you drink per day? __ less than 2 drinks __ more than 2 drinks
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 you have, when did you start drinking less than 2 drinks per day and how much did you drink before then? _____

Do you currently smoke tobacco? __ Yes __ No

If **yes**:
How much do you smoke per day? _____
How long have you been smoking? _____

If **no**:
Have you ever been a smoker? __ Yes __ No
If so:

How much did you smoke? _____
How long were you a smoker? _____
When did you quit? _____

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 so, which drugs did you use and when is the last time you used them?
_____

ALLERGIES Please list any allergies to medications or other substances. Indicate the reaction caused (rash, itching etc.).

_____

_____

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_____ _____

SIGNATURE DATE

Patient (or responsible party)