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 NEUROLOGY, NEUROPHYSIOLOGY



Health Questionnaire

Date _____

Patient's Last Name _____ (First) _____

DOB: _____

What is your reason for coming to see Dr. Kim / Dr. Santamina today?

Review of symptoms: Do you currently have any of the following?

<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Loss of consciousness	<input type="checkbox"/> Seizures
<input type="checkbox"/> Ankle/foot swelling	<input type="checkbox"/> Difficulty with speech	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Sexual dysfunction
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Mood changes	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Fever	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Constipation	<input type="checkbox"/> Head Trauma	<input type="checkbox"/> Numbness	<input type="checkbox"/> Urinary incontinence
<input type="checkbox"/> Depression	<input type="checkbox"/> Headache	<input type="checkbox"/> Paralysis/weakness	<input type="checkbox"/> Vision changes
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Weight loss or gain
<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Rash	<input type="checkbox"/> Other _____

Medications: Please list all medications you are taking. _____

Allergies: Do you have any drug allergies? No Yes _____

If so, what kind of reaction? _____

Medical History: Please list all your medical conditions. _____

Family History: Please list any diseases in your family and the relation of that person to you.

Social History: Do you use tobacco, alcohol, or drugs? If so, which of the following and for how long?

Are you currently driving? Yes No

What are your routine daily or weekly activities? _____

Thank you for filling out this questionnaire!