DFW Neuropathy

New Neuropathy Patient Questionnaire-ROS

6210 Campbell Road St 100 Dallas TX 75248

466 Mid Cities Blvd Hurst TX 76054

919 W Randol Mill Rd Arlington TX 76012

Name: _____
Date: _____
Time: _____
PCP: _____
PCP number: _____
Referred by: _____

1) Do you have pain? Y N Can you rate your pain on a 0 to 10 scale? (0 = No pain, 10 = Worst pain possible)

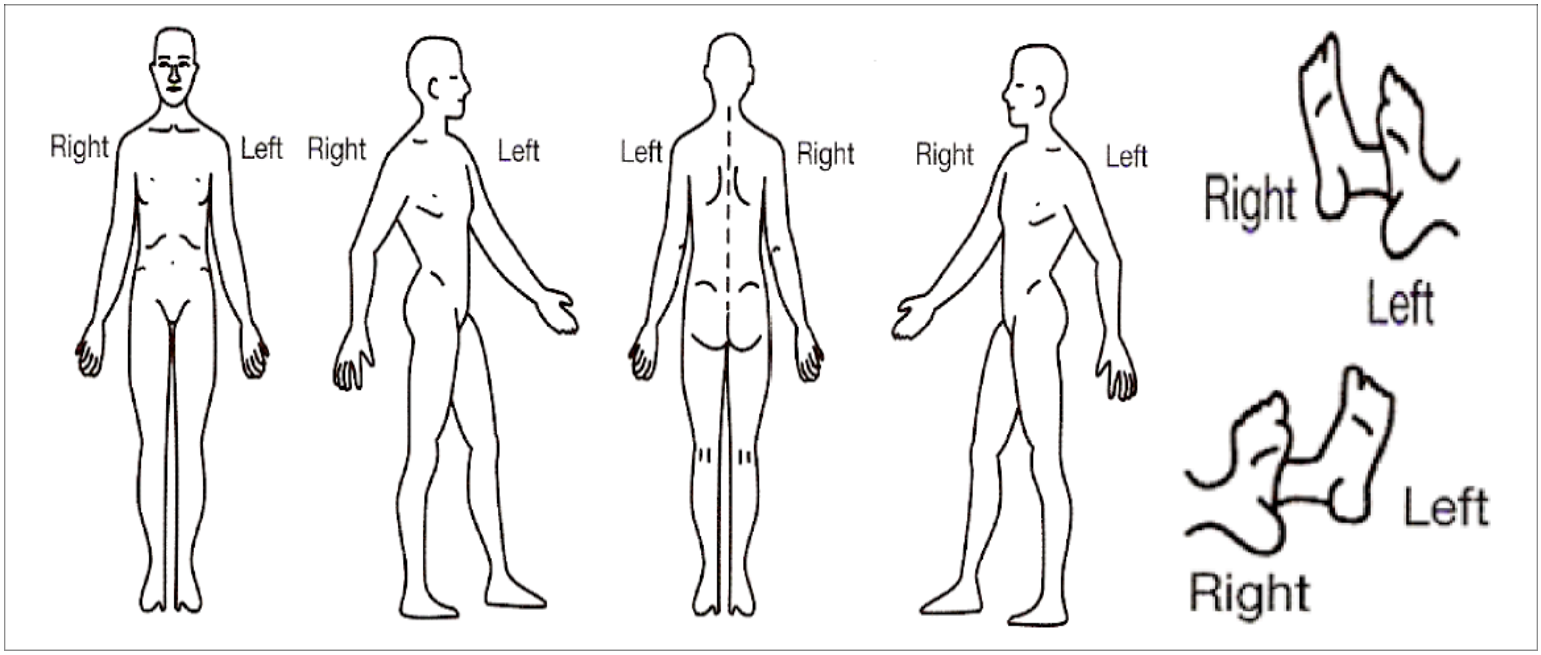
   Pain: 0 1 2 3 4 5 6 7 8 9 10

2) Please describe your symptoms? Aching, burning, throbbing, stabbing, tingling, pins & needle, numbness?

(Please draw below symbols on body diagram)

Ache >>>>>> Numbness = = = = = = Pins & Needles O O O O O O

Burning X X X X X X Stabbing / / / / / / Throbbing Z Z Z Z Z Z



Peripheral Neuropathy Functional Index (PNFI)

3) Circle the number that best describes how your pain or symptoms have interfered with your:

a. **Walking ability:**

Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

b. **Sitting:**

Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

c. **Standing:**

Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

d. **Normal Daily Activities:**

Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

e. **Mood:**

Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

f. **Normal Work (includes both work outside the home and housework):**

Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

g. **Sleep:**

Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

h. **Family Relationship:**

Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

i. **Relationship with your spouse/partner:**

Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

j. **Social activities with other people:**

Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

k. **Enjoyment of life:**

Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

Meaning = Impairment score: 0-20 = Mild; 21-40 = Moderate; 41-60 = Severe; 61-100 = Very severe

4) Do you have pain elsewhere in your body: Neck, back, shoulders, elbows, wrists, knees, or feet? Y N

   a. If so, please describe where? _____

5) Do any of your joints crack, pop, or give away (get weak)? Y N

   a. If so, which joints?_____

6) When do you have your symptoms or pain? (Circle one)

Constant? Intermittent (Come and go)? Only at night? Other times?

7) How long do your symptoms or pains last?

8) When are your symptoms or pains worse? Worse at rest? Worse when more active?

9) Do your symptoms or pains move from one place to another? Y N Where does it travel?

10) What makes your symptoms or pains worse?

11) What makes your symptoms or pains better or ease off?

12) What have you already tried for these symptoms or pains? When was it done and how did it work?

13) What medicines are you taking now for your symptoms or pains?

14) How well do the medicines work to take away your symptoms or pains?

15) Do you have any concerns about the medicines you are taking?

16) Balance Issues:
    a. Do you have any difficulty with your gait or maintaining your balance? Y N

    b. Can you stand from a sitting position without using your hands? Y N

17) Do your symptoms or pains interrupt your sleep? wake up at night or morning with pain? Y N

18) What do your symptoms or pains prevent you from doing?

19) How much relief would let you get around better?

20) What is your goal for relief? (What do you think would be a reasonable achievement in your symptoms?)

21) Do you know if you have arthritis? Y N
    a. If so, where and for how long? _____

22) Do you know if you have neuropathy? Y N
    a. If so, where and for how long? _____

23) Cause of Neuropathy?

Diabetes, Idiopathic (Unknown), ChemoRx induced, Toxic agent, HIV/AIDs, other (Circle one)

24) How was neuropathy diagnosed? This is a very important question. Have you ever had nerve testing? Y N

Neurologist:_____ Type of testing? _____Date:_____

25) Do you have any major medical problems? (**IMPORTANT-**Please circle Yes or No to following questions)

Scarlet Fever	Yes	No	CAD or Heart Attacks	Yes	No	Skin Disorders	Yes	No
Measles	Yes	No	Congestive Heart Failure	Yes	No	Tumor, Cancer, Cysts	Yes	No
German Measles	Yes	No	Diabetes	Yes	No	Venereal Diseases	Yes	No
Rheumatic Fever	Yes	No	High Blood Pressure	Yes	No	HIV +	Yes	No
Mumps	Yes	No	High cholesterol	Yes	No	Jaundice or Hepatitis	Yes	No
Chicken Pox	Yes	No	Dizziness/Fainting	Yes	No	Problems with Urination	Yes	No
Malaria	Yes	No	Weakness/Paralysis	Yes	No	**FEMALES ONLY**		
Tuberculosis	Yes	No	Insomnia	Yes	No	No. Of Pregnancies	Yes	No
Gum or Tooth Problems	Yes	No	Frequent Anxiety or Depression	Yes	No	Irregular Periods	Yes	No
Sinusitis	Yes	No	Recurrent Headaches	Yes	No	Severe Cramps	Yes	No
Eye Trouble	Yes	No	Gallbladder Disease	Yes	No	Excessive flow	Yes	No
Ear, Nose, Throat	Yes	No	Recurrent Diarrhea	Yes	No	**IMMUNIZATIONS**		
Head Injury	Yes	No	Stomach Problems/Ulcers	Yes	No	MMR-Measles/Mumps	Yes	No
Hay Fever/Allergies	Yes	No	Recent Weight Gain or loss	Yes	No	Polio	Yes	No
Asthma	Yes	No	Joint Disease	Yes	No	DPT	Yes	No
Shortness of Breath	Yes	No	Back Problems	Yes	No	Tetanus	Yes	No
Emphysema	Yes	No	Sciatica	Yes	No	Flu Shot	Yes	No
Chest Pain/Pressure	Yes	No	Neck Pain	Yes	No	Pneumovax	Yes	No
Chronic Cough	Yes	No	Blood clots in arms or legs	Yes	No	Mammogram	Yes	No
Rapid Heart Beat	Yes	No	Bloody Stools	Yes	No	Flexible Sigmoidoscopy	Yes	No
Heart murmur	Yes	No	Do you take any blood thinners	Yes	No	Colonoscopy or rectal exam	Yes	No

26) List Hospitalizations & Surgery Dates: (Exact dates are not necessary; your doctor will discuss this with you).

Hospitalizations	Dates	Surgeries	

27) Do you smoke, or have you ever smoked? ____Y ____N

a. If so, how much? _____cig/day, ____packs/day, and for how long? _____months, ____years
b. If you quit, when? ____ how much? ___cig/day, ___packs/day, for how long? ___months, ___years

c. Any significant alcohol use? ____Y ____N Any Illicit Drug use? ____Y ____N

d. Are you Allergic to any Medications?

28) FAMILY MEDICAL HISTORY:

a. Father: _____Alive? _____ State of Health_____

Deceased? ____Age at Death _____ Cause of Death:_____

b. Mother: _____Alive? _____ State of Health_____

Deceased? ____Age at Death _____ Cause of Death:_____

_____ _____

Patient Signature Date