

NEUROLOGICAL ILLNESS QUESTIONNAIRE

use the back &/or other papers if necessary

Name: _____

Age: _____

Brief Occupational category: _____

Time living at your present Address: _____

Date of diagnosis of _____

MEDICATIONS IN THE PAST AND PRESENT:

Chemical exposures: pesticides, solvents, etc.

Neurological presentation, and other symptoms:

Do you have any involuntary 'jerking' movements?

What symptoms did you have first?

In what order did symptoms progress?

Date they began:

Tests for neurological complaints: EMG, MRI scan, blood tests, others?

List results if any.

DO YOU HAVE ANY OF THE FOLLOWING:

Halitosis?

Pain on neck movements?

Pain in other spinal regions?

Swellings?

Rashes?

Headaches?

Increased perspiration?

Sensitivity to cold? to heat?

Cramps?

Tiredness?

Sleep quality - good/poor.

Have you any stomach problems?

Have you any dental infections?

Have you noticed any changes in your sense of smell?

Have you any arthritic symptoms?

Have you any history of rheumatoid arthritis?

Have you any history of autoimmune disease?

Has any family member a history of autoimmune disease or rheumatoid arthritis?

Have you had Tuberculosis? any other serious infection?

Have you had any vaccinations over recent years?

Have you had any viral and or bacterial infections now or within the recent time of your illness?

Do you have any stomach indigestion or acidity?

Have you had any spinal injuries?

Unconsciousness?

Have you traveled abroad within recent years? If yes, to what countries?

What past illnesses have you suffered, *other than* the neurological in question?

FAMILY: Is there any history of neurological symptoms or other illness in your family?

Thank you