CORBETT
NEUROPHYSIOLOGY SERVICES
pure neurophysiology

CONFIDENTIAL PATIENT QUESTIONNAIRE

The following information is requested to ensure that you are correctly identified in our records, to save you time, and to assist us in giving you the best possible care. All of the information which you provide will be treated as being strictly confidential: this practice conforms with the National Privacy Principles, and a copy of our Privacy Policy is available on request.

Please complete this questionnaire before arriving for your appointment **or** arrive 20 minutes early for your appointment and complete it at the clinic.

Title: _____ First Name: _____**Surname: _____ Age**: ____

Date of Birth: _____ Marital Status: _____

Address: _____

_____

Postal Address (if different from above): _____

_____

Phone (Home): _____ **Phone (Work):** _____ **Phone (Mobile):** _____

Occupation: _____ **Email Address:** _____

Emergency Contact Details (name and day/night time telephone numbers):

_____

Referring Doctors Name & Address: _____

General Practitioner (if different to above): _____

Specialists you are currently seeing: _____

Medicare: _____ **Expiry:** _____ **Ref:** _____

Are you a War Veteran? _____ Veteran's Affairs No: _____ Gold Card: _____

The aim in this practice is for patients to be well-informed about their condition, and about any recommendations made for treatment. It is important therefore for you to say at the time if there is anything you do not understand, or about which you wish to know more. An exception to this occurs if you are referred for insurance or medico-legal assessment by a third party, when we are not at liberty to discuss your diagnosis or management.

Our fees for Nerve Conduction and EMG studies and the related clinical consultation are routinely **bulk-billed.** Any other test will be quoted by the receptionist.

PATIENT ACKNOWLEDGEMENT AND CONSENT

I consent to undergo the neurophysiology investigations for which I have been referred. These include nerve conduction studies and may include electromyography studies, if clinically recommended by the attending Neurologist. I have read the information set out on this form. I agree with this information and hereby consent to my medical details including any medical reports being released to my referring medical practitioner(s) and to any other medical practitioner(s) who treats me now or in the future including any other medical practitioner to whom Corbett Neurophysiology Services refers me. My consent is based upon the understanding that such release is intended to be in the best interest of my health. If my referral has been for the purpose of Workcover or Medico-legal assessment, then I consent to the release of any such details or reports to the insurer or my solicitors at their request or to any other party with my solicitor's consent.

I hereby give authorisation for any of my past medical records to be released to Corbett Neurophysiology Services. To the best of my knowledge and belief all of the information I have provided is true and correct.

Signed By: _____ **Date:** _____

What are your **main health problems/symptoms** at present (start with the most troublesome one)?

_____

_____

Smoking & Alcohol:

Do you **smoke?** **….** Yes (number per day: _____) What do you smoke? _____
…. Have you previously smoked (age started: _____ age ceased: _____)
…. Never

How many **evenings per week** do you **drink alcohol?** ___ per week … Never … Special Occasions ...
How many **standard drinks** do you normally have per night? Min: _____ Max: _____ Avg: _____
(A **"standard drink**" is one 285ml glass of standard beer, two 285ml glasses of light beer, small 100ml glass of wine).

Body Weight & Height:

What is your current **body weight?** _____ kg What is your current **height?** _____ cm

Amount of **weight gain** in past 12 months: ____kg or amount of **weight loss** past 12 months: ___ kg

Heart & Circulation:

Do you have **high blood pressure?** …. Yes …. No …. Medicated
Do you have **high cholesterol** and/or **high blood fats?** …. Yes …. No …. Medicated
Have you ever had any of the following **circulatory problems?** (please circle any that apply)

Heart attack (myocardial infarction), heart failure, ischaemic heart disease, atherosclerosis, cardiac bypass surgery, cardiac angioplasty (stent), peripheral oedema (right heart failure), valve replacement, stroke, TIA, palpitations, cardiac arrhythmia (eg: atrial fibrillation, ventricular ectopy)

What is the name of your **cardiologist?** _____

Have you had an **echocardiogram** performed recently? …. Yes …. No (if yes, where? _____

Lung Disease:

Have you ever had any of the following **lung problems** (please circle)?

Obstructive lung disease (eg: COPD, asthma). chest wall disease (eg: kyphoscoliosis), hypercapnic respiratory failure (increased CO2), emphysema

Details: _____

What is the name of your **respiratory physician?** _____

Restless Legs / Peripheral Nerves:

Do you get an **irresistible urge to move your legs** or **uncomfortable sensations** in your legs when you sit down and relax at the end of the day or when you are in bed at night? 0 1 2 3
Is the urge to move your legs **partially or totally relieved by moving** them? …. Yes …. No
Do you get numbness or a *"pins and needles"* sensations in your hands or feet? …. Yes …. No

Any additional comments: _____

General Medical History: (please circle the condition and indicate approximately when it was diagnosed)

Kidney disease, kidney stones, bladder problems _____

Gastric or duodenal ulcer, bowel disorder, liver disorder _____

Hepatitis A, B, C; contact with HIV/AIDS _____

Anaemia, excessive bleeding, other blood disorders _____

Diabetes, thyroid disorder, other endocrine disorder _____

Anxiety, depression, other psychiatric disorder _____

Arthritis, joint or bone disorder _____

Neuromuscular disease (eg; muscular dystrophy) _____

Epilepsy, seizures, blackouts, other neurological disorder _____

Overweight, obesity, OSA/CPAP treatment _____

Do you take any **non-prescribed** or **recreational drugs? (please specify)** _____

Do you have any **allergies?** _____

Have you had any serious **accidents** or **past hospital admissions? (indicate approx. date & details)**

_____

_____

Please list all current medications:

Medication Name	Reason for Medication	Dosage

If there is not enough room on this page to list your medications, please attach a separate sheet

Family History:

Please indicate any known family diseases (if deceased, please indicate the cause of death and age at death):

Mother: _____ Father: _____

Maternal Grandmother _____ Maternal Grandfather _____

Paternal Grandmother _____ Paternal Grandfather _____

Please note any **other health-related information** you feel is relevant: _____

_____

_____

_____