EMORY
BRAIN HEALTH CENTER

EMORY
CLINIC

Emory Clinic Department of Neurological Surgery

**Second Opinion Questionnaire**

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First Name: ____________________ M.I. ______ Last Name: ________________________________

Date of Birth: ____________________ Phone: ______________________________

Marital Status:
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Single

Work Status:
- ☐ Employed
- ☐ Worker's Compensation
- ☐ Retired
- ☐ Disabled
- ☐ Unemployed

General Health Status
- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Dominant Hand
- ☐ Right
- ☐ Left
- ☐ Ambidextrous

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**Please list below any treating or referring physicians you would like to have a copy of your written second opinion report forwarded to after completion:**

**Treating/Referring Physician**

Name: ____________________________________________ Fax #: ___________________________

Address: __________________________________________ Phone #: _________________________

City: _____________________________________________ State: ______ Zip: ________________

**Treating/Referring Physician**

Name: ____________________________________________ Fax #: ___________________________

Address: __________________________________________ Phone #: _________________________

City: _____________________________________________ State: ______ Zip: ________________

**What medical problems or symptoms are you requesting a second opinion for?**

| Medical Problem/Symptom | Onset Date |
| --- | --- |
| | |
| | |
| | |

**What explicit questions do you want answered within your second opinion?**

**Do you now or have you ever had the following:**

| | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Heart problems | ☐ | Yes | ☐ | No | Diabetes or problems with blood sugar | ☐ Yes | ☐ No |
| Lung problems | ☐ | Yes | ☐ | No | GI problems (i.e. ulcers, hiatal hernia, gastritis) | ☐ Yes | ☐ No |
| Kidney problems | ☐ | Yes | ☐ | No | Liver disease (such as hepatitis) | ☐ Yes | ☐ No |
| High blood pressure | ☐ | Yes | ☐ | No | Problems with blood (i.e. clotting problems) | ☐ Yes | ☐ No |
| Any type of cancer | ☐ | Yes | ☐ | No | | | |

**Please list any other medical problems:**

**Please list any surgical procedures that you have had:**

| Surgical Procedure | Date | Facility/Hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

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**Name:** ______________________ **Date of Birth:** ______________________

## SOCIAL HISTORY

Alcohol Use: ☐ Yes ☐ No How much per day? ______________________

Tobacco Use: ☐ Yes ☐ No How much per day? ______________________

Illicit Drug Use: ☐ Yes ☐ No How much per day? ______________________

Physical Activity: ☐ Yes ☐ No Type: __________ Days/Week: ________ Mins/Day: ________

How many times have you fallen in the last year? __________ Were you injured? ☐ Yes ☐ No

## ALLERGIES & MEDICATIONS

**Please list ALL prescription medications, over-the-counter medications, and vitamins/supplements that you are taking:**

| Medication | Dosage | # of Pills/Times Taken Per Day | Method/Route (Ex. By Mouth) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
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| | | | |
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| | | | |

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**Please list any allergies you have (drugs and other substances):**

Drug/Substance

Reaction

**Have you ever had a reaction to any dye given for a special test?** ☐ Yes ☐ No

**If so, what was the test and what kind of reaction did you have?**

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**Name:** ______________________ **Date of Birth:** ______________________

**Are you on a special diet?** ☐ Yes ☐ No

**If so, please specify the type of diet:**

______________________

______________________

## FAMILY HISTORY

**Has anyone in your immediate family had:**

| | | | |
|---|---|---|---|
| High blood pressure | ☐ Yes | ☐ No | If so, who? ______ |
| Heart disease | ☐ Yes | ☐ No | If so, who? ______ |
| Cancer | ☐ Yes | ☐ No | If so, who? ______ |
| Diabetes | ☐ Yes | ☐ No | If so, who? ______ |
| Asthma | ☐ Yes | ☐ No | If so, who? ______ |
| Stroke | ☐ Yes | ☐ No | If so, who? ______ |
| Seizures | ☐ Yes | ☐ No | If so, who? ______ |
| Migraine | ■ Yes | ■ No | If so, who? ______ |

**Please list other illnesses/diseases that your immediate family members have had:**

______________________

______________________

______________________

| | Alive (Current Age) | Deceased (Age) | Health Status | Cause of Death |
|---|---|---|---|---|
| **Father** | | | | |
| **Mother** | | | | |
| **Brother(s)** | | | | |
| | | | | |
| **Sister(s)** | | | | |
| | | | | |
| **Children** | | | | |
| | | | | |

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Name: ____________________ Date of Birth: ____________________

**REVIEW OF SYSTEMS**

**Please check any of the symptoms you are currently experiencing:**

| No | Yes | **Neurological/Psychiatric** |
|---|---|---|
| ☐ | ☐ | Seizures |
| ☐ | ☐ | Headaches |
| ☐ | ☐ | Blackouts |
| ☐ | ☐ | Dizziness |
| ☐ | ☐ | Double Vision |
| ☐ | ☐ | Paralysis or Weakness of Limb(s) |
| ☐ | ☐ | Loss of Sensation |
| ☐ | ☐ | Loss of Balance |
| ☐ | ☐ | Loss of Coordination |
| ☐ | ☐ | Difficulty in Speaking |
| ☐ | ☐ | Nervousness |
| ☐ | ☐ | Depression |
| ☐ | ☐ | Difficulty in Going to Sleep |
| ☐ | ☐ | Early Morning Awakening |
| ☐ | ☐ | Difficulty Remembering Past Events |
| ☐ | ☐ | Difficulty Remembering Recent Events |
| ☐ | ☐ | Difficulty with Thinking/Problem Solving |

| No | Yes | **Musculoskeletal** |
|---|---|---|
| ☐ | ☐ | Muscle Pain |
| ☐ | ☐ | Neck Pain |
| ☐ | ☐ | Shoulder or Arm Pain |
| ☐ | ☐ | Back Pain |
| ☐ | ☐ | Pain Down Right Leg |
| ☐ | ☐ | Pain Down Left Leg |
| ☐ | ☐ | Painful Joints |
| ☐ | ☐ | Swelling of any joints |
| ☐ | ☐ | Redness of any joints |
| ☐ | ☐ | Stiffness of any joints |
| ☐ | ☐ | Deformities of the joints or extremities |

| No | Yes | **Cardiovascular** |
|---|---|---|
| ☐ | ☐ | Chest Pain, Tightness, or Squeezing |
| ☐ | ☐ | Shortness of Breath when Lying Down |
| ☐ | ☐ | Need to Sit Up to Breathe |
| ☐ | ☐ | Heart Racing |
| ☐ | ☐ | Irregular Heart Beat (Palpitations) |
| ☐ | ☐ | Heart Murmur |
| ☐ | ☐ | Swelling of the Legs |
| ☐ | ☐ | Varicose Veins |

| No | Yes | **General** |
|---|---|---|
| ☐ | ☐ | Weakness |
| ☐ | ☐ | Tiredness |
| ☐ | ☐ | Lack of Appetite |
| ☐ | ☐ | Excess Appetite |
| ☐ | ☐ | Weight Loss |
| ☐ | ☐ | Weight Gain |
| ☐ | ☐ | Chills |
| ☐ | ☐ | Fever |
| ☐ | ☐ | Night Sweats |
| ☐ | ☐ | Difficulty Sleeping |

| No | Yes | **Vision/ENT** |
|---|---|---|
| ☐ | ☐ | Decreased Ability to See |
| ☐ | ☐ | Blurred Vision |
| ☐ | ☐ | Spots Before Your Eyes |
| ☐ | ☐ | Pain in the Eyes |
| ☐ | ☐ | Difficulty in Hearing |
| ☐ | ☐ | Ringing in the Ears |
| ☐ | ☐ | Discharge from the Ears |
| ☐ | ☐ | Nasal Discharge (Frequent) |

| No | Yes | **Gastrointestinal** |
|---|---|---|
| ☐ | ☐ | Nausea |
| ☐ | ☐ | Vomiting |
| ☐ | ☐ | Diarrhea |
| ☐ | ☐ | Constipation |
| ☐ | ☐ | Heartburn |
| ☐ | ☐ | Abdominal Pain |
| ☐ | ☐ | Bright Red Blood in Stools |
| ☐ | ☐ | Black Stools |
| ☐ | ☐ | Change in Bowel Habits |
| ☐ | ☐ | Need for Antacids |

| No | Yes | **Urinary** |
|---|---|---|
| ☐ | ☐ | Urinary tract infections |
| ☐ | ☐ | Pain or burning on urination |
| ☐ | ☐ | Frequent urination – day |
| ☐ | ☐ | Frequent urination – night |
| ☐ | ☐ | Unusually large volumes of urine |
| ☐ | ☐ | Extreme urge to urinate |

| | | | | | |
|---|---|---|---|---|---|
| ☐ | ☐ | Leg Pain at Rest | ☐ | ☐ | Difficulty starting urinary stream |
| ☐ | ☐ | Leg Pain with Exertion | ☐ | ☐ | Difficulty stopping urinary stream |
| ☐ | ☐ | Blue/Purple Discoloration of Hands/Feet | ☐ | ☐ | Kidney stones |

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| No | Yes | **Respiratory** |
|---|---|---|
| ☐ | ☐ | Cough |
| ☐ | ☐ | Wheezing |
| ☐ | ☐ | Asthma |
| ☐ | ☐ | Shortness of Breath |
| ☐ | ☐ | Shortness of Breath with Exertion |
| ☐ | ☐ | Pain in Chest During Cough/Sneeze, |
| ☐ | ☐ | Moving |

| No | Yes | **Genito-Reproductive (Male)** |
|---|---|---|
| ☐ | ☐ | History of Sexually Transmitted Disease |
| ☐ | ☐ | Discharge from Penis |
| ☐ | ☐ | Testicular Pain |
| ☐ | ☐ | Lumps in Testicles or Scrotum |
| ☐ | ☐ | Decrease in Testicular Size |
| ☐ | ☐ | Decreased Sexual Desire |
| ☐ | ☐ | Decreased Ability to Achieve Erection |

| No | Yes | **Genito-Reproductive (Female)** |
|---|---|---|
| ☐ | ☐ | History of Sexually Transmitted Disease |
| ☐ | ☐ | Decreased Sexual Drive |
| ☐ | ☐ | Vaginal Bleeding Since Menopause |
| ☐ | ☐ | Hot Flashes |
| ☐ | ☐ | Are You Taking Any Female Hormones? |
| ☐ | ☐ | Do You Ever Bleed Between Periods? |

____________ What is the Date of Your Last Normal Period?

____________ What is the Date of Your Period Before That?

____________ How Far Apart Are Your Periods?

____________ How many days do they last?

____________ Is Flow Heavy, Scanty, or Normal?

____________ Age at Onset of Menstrual Periods

____________ Age at Which Periods Stopped (Menopause)

| No | Yes | **Skin** |
|---|---|---|
| ☐ | ☐ | Dryness of Skin |
| ☐ | ☐ | Itching |
| ☐ | ☐ | Rash |
| ☐ | ☐ | Change in Skin Color |
| ☐ | ☐ | Change in Texture of the Hair |
| ☐ | ☐ | Change in Skin Temperature |
| ☐ | ☐ | Falling Out of the Hair |
| ☐ | ☐ | Nail Changes |
| ☐ | ☐ | Skin Ulcers |

| No | Yes | **Endocrine** |
|---|---|---|
| ☐ | ☐ | Goiter |
| ☐ | ☐ | Heat Intolerance |
| ☐ | ☐ | Cold Intolerance |
| ☐ | ☐ | Tremulousness of the Hands |
| ☐ | ☐ | Change in Pitch of the Voice |
| ☐ | ☐ | Increased Body Hair |
| ☐ | ☐ | Decreased Body Hair |
| ☐ | ☐ | Decrease in Breast Size |
| ☐ | ☐ | Loss of Periods (Not Due to Menopause) |

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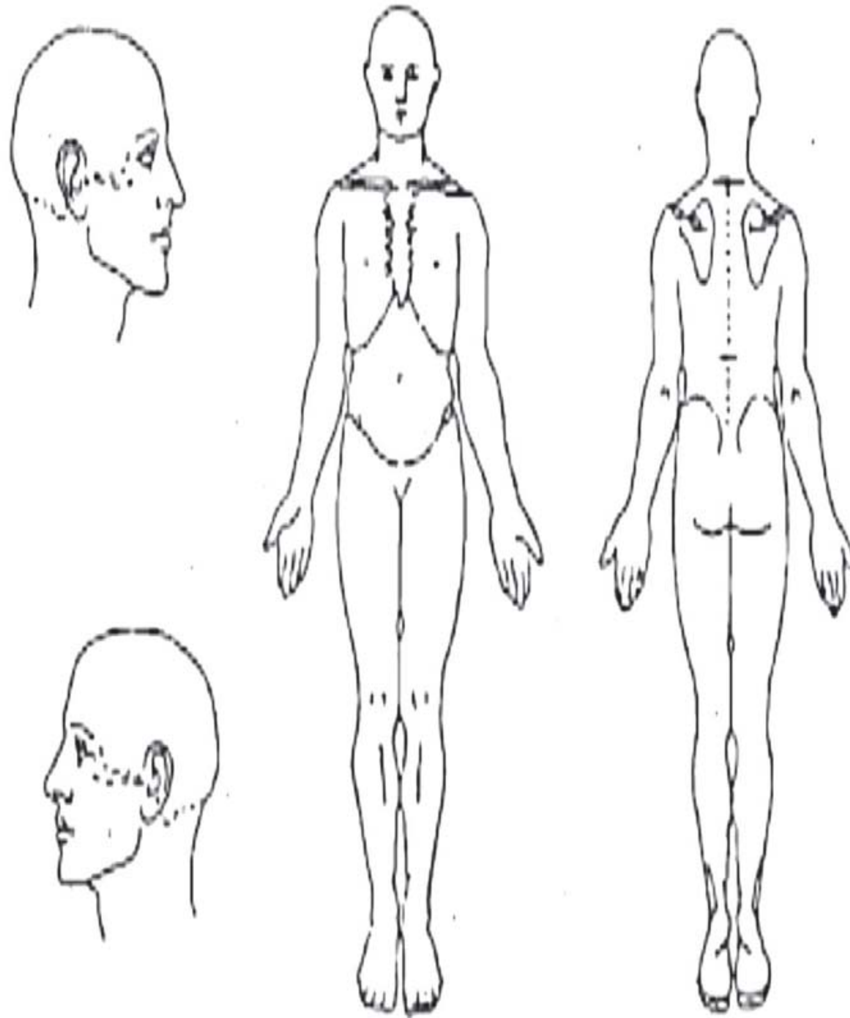
**Name:** ______________________________ **Date of Birth:** ____________________

**Are you experiencing pain, numbness, or tingling at the present time?** ☐ Yes ☐ No

**If yes, please indicate with an 'X' on the following diagram the location of your symptoms:**



**Severity:** ☐ Constant ☐ Occasional ☐ Wakes You Up ☐ Difficulty Walking

**Description:** ☐ Aches ☐ Tingles ☐ Throbs ☐ Stabbing ☐ Burns☐ Numbness

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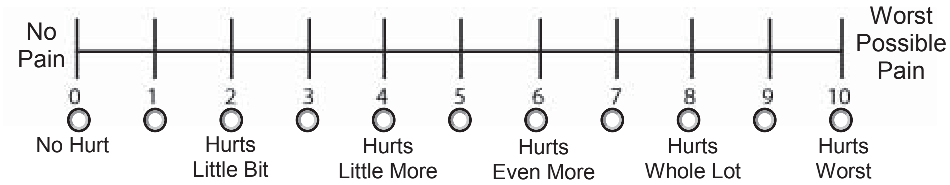
**Indicate your current pain level on the following scale:**




**What makes your condition worse?** ______________________________

**What helps your condition?** ______________________________

**Other body parts affected:** ______________________________

**Symptoms affected by:** ______________________________

**What kind of effect do the following situations have on your symptoms?**

| | | | | | |
|---|---|---|---|---|---|
| **Sitting:** | ☐ Increase | ☐ Decrease | **Standing:** | ☐ Increase | ☐ Decrease |
| **Exercise:** | ☐ Increase | ☐ Decrease | **Resting:** | ☐ Increase | ☐ Decrease |