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PARKINSON'S DISEASE CENTER  
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**NEW PATIENT QUESTIONNAIRE**  
**PLEASE FILL OUT COMPLETELY: USE "N/A" IF NOT APPLICABLE**

Today's Date (mm/dd/yyyy): \_\_\_ / \_\_\_ / \_\_\_\_\_

NAME: Last \_\_\_\_\_, First \_\_\_\_\_, Middle Initial \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone # (\_\_\_\_) - \_\_\_\_\_

Work/Cell Phone#: (\_\_\_\_) - \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_

Contact # (\_\_\_\_) - \_\_\_\_\_

Name and Address of Referring Physician:

Name and Address of Primary Care Physician:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone#: (\_\_\_\_) - \_\_\_\_\_

Phone#: (\_\_\_\_) - \_\_\_\_\_

FAX#: (\_\_\_\_) - \_\_\_\_\_

FAX#: (\_\_\_\_) - \_\_\_\_\_

Date of Birth: (mm/dd/yyyy) \_\_\_ / \_\_\_ / \_\_\_\_\_

How many years of school have you completed? \_\_\_\_\_

Handedness (circle one): Right Left Ambidextrous

Occupation: \_\_\_\_\_

Marital status: (circle one) S M D W

How Long? \_\_\_\_\_

Current Status FT \_\_\_ PT \_\_\_ Retired \_\_\_ Disabled \_\_\_

Student \_\_\_ Unemployed \_\_\_\_\_

What is the reason for your office visit? \_\_\_\_\_  
\_\_\_\_\_

List **Any Allergies** to Medications (Name of drug and reaction):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List **ALL** Surgical Procedures done: (Type and date):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PAST MEDICAL HISTORY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please circle below any tests you have had for your current condition:

MRI SPINE      MRI BRAIN      CT SCAN BRAIN      OTHER IMAGING \_\_\_\_\_

EMG/NERVE CONDUCTION STUDIES      EEG (Electroencephalogram)

SLEEP STUDIES

Genetic testing? Yes / No      Any special lab test for this condition? Yes / No      If yes please list: \_\_\_\_\_

**→ TURN OVER AND COMPLETE THE BACK PAGE ←**

Please list **ALL** medications you are currently taking (attach a separate page if needed and include herbals/nutritional supplements and over-the-counter medications):

Name of medication	Dose	Frequency	Reason for taking	Taken for how long?
1				
2				
3				
4				
5				
6				
7				

Relative	Age or Age at death	Deceased?	Medical and/or Neurologic Condition(s)
Mother			
Father			
Sisters			
Brothers			
Sons			
Daughters			
Others			

**Please Circle any Condition(s) That Apply To You Within The Last Eight Weeks:**

**GENERAL:** fever, weight gain/loss, fatigue, other \_\_\_\_\_

**EYES:** vision loss, blurry vision, double vision, other: \_\_\_\_\_

**EAR/NOSE/THROAT:** loss of smell, hearing loss, voice changes, other: \_\_\_\_\_

**CARDIAC:** chest pains, palpitations, irregular heartbeat, lightheadedness, other: \_\_\_\_\_

**RESPIRATORY:** shortness of breath, cough, asthma, other: \_\_\_\_\_

**GI:** ulcers, reflux, nausea/vomiting, diarrhea, constipation, other: \_\_\_\_\_

**GU:** losing control of bladder, increased urinary frequency, increased urgency, sexual dysfunction, post-menopausal, surgically sterile, other \_\_\_\_\_

**BLOOD:** anemia, easy bruising, bleeding or clotting disorder, other: \_\_\_\_\_

**MUSCULOSKELETAL:** joint swelling, joint pain, arthritis, muscle aches, ankle swelling, other: \_\_\_\_\_

**ENDOCRINE:** heat or cold intolerance, losing hair, diabetes, thyroid problems, other: \_\_\_\_\_

**SKIN:** rashes, suspicious lesions, change in skin color, other: \_\_\_\_\_

**PSYCHIATRIC:** hallucinations, delusions, memory loss, depression, anxiety, bipolar, OCD, ADD, ADHD, other: \_\_\_\_\_

**NEUROLOGIC:** tremor, stiffness, gait imbalance, numbness, tingling, headaches, seizures, strokes, other: \_\_\_\_\_

**SLEEP:** can't get to sleep, can't stay asleep, restless legs, acting out dreams, sleep apnea, other: \_\_\_\_\_

**Social History:**

**Tobacco Use:** Cigarettes: Yes / No Cigars: Yes / No Pipe: yes / no Smokeless (Chew/Snuff): Yes / No

If yes, what quantity? \_\_\_\_\_/day How long? \_\_\_\_\_ Prior Smoker: Yes / No How long? \_\_\_\_\_

**Alcohol Use:** (circle all that apply): Beer Wine Liquor Hooch **Caffeine use:** Yes / No

If yes, amount per week \_\_\_\_\_ If yes, amount per week \_\_\_\_\_

**Other:** Do you use recreational or intravenous drugs? Yes / No

If yes, please list: \_\_\_\_\_

**➔ PLEASE MAKE SURE YOU HAVE COMPLETED THE FRONT OF THIS FORM ⬅**