Dr Desiree Fernandez
MB BCh BAO MRCP(UK) MD FRACP
Consultant Neurologist
MCNZ 64709

TOP OF THE SOUTH
NEUROLOGY

New Patient Questionnaire

The following questionnaire is to help us obtain your medical history which will be relevant to your upcoming clinic consultation.

Name: DOB:
Right or left handed: Occupation:
Email Address:
Marital Status:

1. Brief description of symptoms:

2. Any recent change in symptoms:

3. Medication list (including contraceptives, health food supplements or herbal therapy):

4. Any drug allergy:

5. Past medical and surgical history (please write on a separate sheet, if necessary):

6. Family history of any neurological illness:

7. Smoking history, if any (past or present, please state how many cigarettes per day):

8. Alcohol intake, if any (please state amount):

9. Illicit drug use, if any:

10. Any other relevant information:

PO Box 3744, Richmond 7050, New Zealand
Tel 021 059 8818 **Fax** 03 929 5786 **Email** neurology@topofthesouthclinic.nz
www.topofthesouthclinic.nz

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Headache questionnaire
(Please answer only if you have headache)

1. Name:
2. How old were you when you had your 1st ever headache (even if this was mild)?
3. Any past or present motion sickness:
4. Brief description of your headache (eg which side of the head, any other accompanying symptoms):
5. Severity of headache on a scale of 1/10 (mild) to 10/10 (severe):
6. Duration of each headache:
7. Number of headache days per month, in the last 3 months:
8. How many days in a week do you need to take pain medications:
9. Does anything trigger or precipitate your headache; or make it worse:
10. Medications previously tried (please state the duration and dose if you can recall; and also whether this medication was effective for your headache):
11. How much caffeine do you drink per day (please include tea, coffee and caffeinated drinks eg cola, V energy drinks, Red Bull etc):
12. Do you sleep well (please include details on sleep and wake time)?
13. Do you eat your meals regularly?
14. Do you exercise regularly (please include details of how frequent and what type of exercise)?
15. Any family history of headache:
16. How has your headache affected your daily life?

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