NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

NAME:_____ DATE:_____

For any YES answer, please notify the Doctor.

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Comment:_____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Comment:_____
3. Do your hands or arms fall asleep regularly? NO YES
   Comment:_____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Comment:_____
5. Do you suffer from a loss of handgrip strength? NO YES
   Comment:_____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Comment:_____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Comment: _____
8. Do your legs or feet fall asleep regularly? NO YES
   Comment:_____
9. Do you have reduced feeling (sensation) or swellings in your legs, feet? NO YES
   Comment:_____
10. Do you suffer from cold hands or feet? NO YES
    Comment:_____
11. Do you suffer from headaches, dizziness or memory loss? NO YES
    Comment:_____
12. Do you have difficulty maintaining your balance? NO YES
    Comment:_____
13. Do you suffer from vertigo or blurred vision? NO YES
    Comment:_____
14. Do you suffer from a reduced hearing capacity? NO YES
    Comment:_____
15. Do you suffer from ringing in your ears? NO YES
    Comment:_____
16. Do you have bladder or bowel control problems on a regular basis? NO YES
    Comment:_____