Lions Gate Neurosciences

Pre-Visit Questionnaire

Name: _____

Date of Birth: _____ Race: _____

Phone: _____ Cell Phone: _____

Email: _____

Best contact method: _____ Preferred Pronouns: _____

Family Doctor & Specialists: _____

Preferred Pharmacy (Name + Location): _____

Height: _____ Weight: _____

Current/Previous Job: _____ Are you left or right-handed? _____

Do you drive? _____ Do you live alone or with others?_____

Reason for Referral/Chief Complaint: _____

Past Medical History/Chronic Health Conditions: Place a ✓ in the column(s) that apply.

	Yes	No		Yes	No
High Blood Pressure			Thyroid Disease		
High Cholesterol			Asthma		
Diabetes			Migraine Headaches		
Stroke			Cancer		
Heart Disease			Other (specify below)		

Other: _____

Past Surgeries: _____

Allergies: _____

Review of Recent Symptoms: Place a ✓ in the box(es) that apply.

☐ Unexpected Weight Loss ☐ Night Sweats ☐ Fainting/Lightheadedness

☐ Dry Eyes and Dry Mouth ☐ Constipation ☐ Chest Pain

☐ Shortness of Breath ☐ Palpitations ☐ Early Satiety/Loss of Appetite

☐ New Skin Rashes ☐ Incontinence ☐ Other: _____

☐ Other (continued): _____

Current Medications:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

What disease(s), if any, are present in your family members, particularly **ages less than 65**:

_____

Neurologic disease(s):

_____

Have you ever smoked cigarettes? _____ If so, from what ages? _____ How much? _____

How many alcoholic drinks do you have per week? _____

Do you use any other substances? _____