

The Fresco Institute for Parkinson's and Movement Disorders

Follow Up Patient Questionnaire

Name: _____ Date: _____

Accompanied by: _____ Do you smoke? CURRENT PAST NEVER

Which neurological symptom bothers you most right now? _____

Any new medical problems, hospitalizations, surgeries, or allergies (since your last visit)? Y N

If yes, then please explain: _____

Medications, Vitamins, & Supplements (or attach your own list):

Medication Name	Dose (or # of mg)	Time:	Time:	Time:	Time:	Time:	Time:

PD NMS QUESTIONNAIRE

Name:

Date:

Age:

Centre ID:

Male

Female

NON-MOVEMENT PROBLEMS IN PARKINSON'S

The movement symptoms of Parkinson's are well known. However, other problems can sometimes occur as part of the condition or its treatment. It is important that the doctor knows about these, particularly if they are troublesome for you.

A range of problems is listed below. Please tick the box 'Yes' if you have experienced it **during the past month**. The doctor or nurse may ask you some questions to help decide. If you have **not** experienced the problem in the past month tick the 'No' box. You should answer 'No' even if you have had the problem in the past but not in the past month.

Have you experienced any of the following in the last month?

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Dribbling of saliva during the daytime | <input type="checkbox"/> | <input type="checkbox"/> | 16. Feeling sad, 'low' or 'blue' | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Loss or change in your ability to taste or smell | <input type="checkbox"/> | <input type="checkbox"/> | 17. Feeling anxious, frightened or panicky | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Difficulty swallowing food or drink or problems with choking | <input type="checkbox"/> | <input type="checkbox"/> | 18. Feeling less interested in sex or more interested in sex | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Vomiting or feelings of sickness (nausea) | <input type="checkbox"/> | <input type="checkbox"/> | 19. Finding it difficult to have sex when you try | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Constipation (less than 3 bowel movements a week) or having to strain to pass a stool (faeces) | <input type="checkbox"/> | <input type="checkbox"/> | 20. Feeling light headed, dizzy or weak standing from sitting or lying | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Bowel (fecal) incontinence | <input type="checkbox"/> | <input type="checkbox"/> | 21. Falling | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Feeling that your bowel emptying is incomplete after having been to the toilet | <input type="checkbox"/> | <input type="checkbox"/> | 22. Finding it difficult to stay awake during activities such as working, driving or eating | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. A sense of urgency to pass urine makes you rush to the toilet | <input type="checkbox"/> | <input type="checkbox"/> | 23. Difficulty getting to sleep at night or staying asleep at night | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Getting up regularly at night to pass urine | <input type="checkbox"/> | <input type="checkbox"/> | 24. Intense, vivid dreams or frightening dreams | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Unexplained pains (not due to known conditions such as arthritis) | <input type="checkbox"/> | <input type="checkbox"/> | 25. Talking or moving about in your sleep as if you are 'acting' out a dream | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Unexplained change in weight (not due to change in diet) | <input type="checkbox"/> | <input type="checkbox"/> | 26. Unpleasant sensations in your legs at night or while resting, and a feeling that you need to move | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Problems remembering things that have happened recently or forgetting to do things | <input type="checkbox"/> | <input type="checkbox"/> | 27. Swelling of your legs | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Loss of interest in what is happening around you or doing things | <input type="checkbox"/> | <input type="checkbox"/> | 28. Excessive sweating | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Seeing or hearing things that you know or are told are not there | <input type="checkbox"/> | <input type="checkbox"/> | 29. Double vision | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Difficulty concentrating or staying focussed | <input type="checkbox"/> | <input type="checkbox"/> | 30. Believing things are happening to you that other people say are not true | <input type="checkbox"/> | <input type="checkbox"/> |

All the information you supply through this form will be treated with confidence and will only be used for the purpose for which it has been collected. Information supplied will be used for monitoring purposes. Your personal data will be processed and held in accordance with the Data Protection Act 1998.

Developed and validated by the International PD Non Motor Group
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