Parkinson's Disease Patient Questionnaire

Name: _____ **Date**: _____ **Height:** _____ **Weight:** _____

Please use the check boxes to the right of each question to enter Yes or No.

1.	If you have Parkinson disease, do you get screened for melanoma?	**Yes** ❑ No ❑
2.	Are you experiencing side effects from neurological medicines?	**Yes** ❑ No ❑
3.	Have you fallen since you last saw the doctor?	**Yes** ❑ No ❑
4.	Have you had any difficulty controlling your bladder or bowels?	**Yes** ❑ No ❑
5.	Do you ever feel dizzy?	**Yes** ❑ No ❑
6.	Have you ever seen or heard things that you know or are told are not there?	**Yes** ❑ No ❑
7.	Do you feel sad, depressed, guilty, "low," or "blue?"	**Yes** ❑ No ❑
8.	Have you lost interest in what is happening around you or doing things?	**Yes** ❑ No ❑
9.	Do you have difficulty concentrating or staying focused?	**Yes** ❑ No ❑
10.	Do you ever feel anxious, frightened, or panicky?	**Yes** ❑ No ❑
11.	Do you have an increased interest in eating, sex, gambling, or shopping?	**Yes** ❑ No ❑
12.	Have any of your friends or family members been concerned about a change in your behavior?	**Yes** ❑ No ❑
13.	Do you have problems with your memory?	**Yes** ❑ No ❑
14.	Do you have difficulty staying awake during the day?	**Yes** ❑ No ❑
15.	Do you have difficulty getting to sleep or staying asleep at night?	**Yes** ❑ No ❑
16.	Do you experience gasping, choking or stopping breathing at night?	**Yes** ❑ No ❑
17.	Do you have intense, vivid, or frightening dreams?	**Yes** ❑ No ❑
18.	Do you talk or move in your sleep as if you are acting out a dream?	**Yes** ❑ No ❑
19.	Do you have unpleasant sensations in your legs at night, with a feeling that you need to move your legs?	**Yes** ❑ No ❑
20.	Do you have uncontrollable movements at times during the day?	**Yes** ❑ No ❑
21.	Do your Parkinson's symptoms worsen during the day or night?	**Yes** ❑ No ❑
22.	Which of these symptoms bothers you the most?	
23.	Have you lost more than 5 pounds over the past 6 months?	**Yes** ❑ No ❑
24.	Any new allergies?	**Yes** ❑ No ❑

Review of symptoms (includes constitutional (weight loss), ENT (dizzy), respiratory (gasping, choking or stopping breathing), GI (bowels), genitourinary (bladder), musculoskeletal (uncontrollable movements), integumentary (melanoma), neurological (memory loss), psychiatric (depressed), endocrine (sex), allergic (allergies)