Patient assessment questionnaire - Stroke

Auckland Neurosurgical Clinic Ltd

Name:	Male/Female (please delete)
Date of birth:	E-mail Address:
Address:	
	Postcode:
Telephone number: (day)	(evening)
Doctor's name and address:	
	Postcode:
Insurers name and address:	
	Postcode:
Occupation:	

		(Please circle)			
1.	Have you had transient weakness of an arm? Which side?	Yes	No	R	L
2.	Have you had transient weakness of a leg? Which side?	Yes	No	R	L
3.	How long did the weakness last?				
4.	Have you ever had speech difficulties?	Yes	No		
5.	When did the current problems start?				
6.	Do you have high Cholesterol?	Yes	No		
7.	Do you have Diabetes?	Yes	No		
8.	Have you ever had angina or a heart attack?	Yes	No		
9.	If answer to question 8 is yes, what treatment are you taking?				
10.	Do you smoke? If so how much and for how long?	Yes	No		
11.	What is your height?				
12.	What is your weight?				
13.	Have you had any surgery in the past?	Yes	No		
14.	What operation/s was/were performed?				
15.	Date and place of surgery:				
16.	Have you had any illnesses in the past?	Yes	No		

If yes please list-

Current Medication:

Aspirin	Yes	No	Plavix(Clopidogrel)	Yes	No
Warfarin	Yes	No			