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Patient assessment questionnaire – Facial Pain & Numbness

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:
ACC Number	Case Manager
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.	Have you ever had loss of vision?	Yes	No	
7.	Do you have high Cholesterol?	Yes	No	
8.	Do you have Diabetes?	Yes	No	
9.	If answer to question 9 is yes, what treatment are you taking?			
10.	Have you ever had facial pain?	Yes	No	
11.	Have you ever had facial numbness?	Yes	No	
12.	Have you had seizures?	Yes	No	
13.	What is your weight?			
14.	Have you had any surgery in the past?	Yes	No	
15.	What operation/s was/were performed?			
16.	Date and place of surgery:			
17.	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		