Patient assessment questionnaire
Pituitary Tumour

Auckland Neurosurgical Clinic Ltd

Name:	Sex: Male / Female
Address:	E-mail Address:
	Date of Birth:
Telephone number: (day) (evening)	
GP Name & Address:	
Insurers name and address: Postcode:	
Occupation:	

	(Please circle)	
1. Do you have headache?	Yes	No
2. Do you suffer from nausea and vomiting?	Yes	No
3. When did the current problems start?		
4. Do you have any visual problems?	Yes	No
5. Have you been extremely thirsty?	Yes	No
6. Have you had any physical changes, face, hands, feet or body?	Yea	No
7. Do you have numbness in arms or legs?	Yes	No
8. Do you have weakness of the arms or legs?	Yes	No
9. Have you ever had a seizure?	Yes	No
10. If you answered yes to question 8, when was your last seizure?		
11. Have you been incontinent of urine?	Yes	No
12. Have you had any surgery in the past?	Yes	No
13. What operation/s was/were performed?		
14. Date and place of surgery:		
15. 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			