NEW SMYRNA WELLNESS CENTER

NEUROPATHY QUESTIONAIRE

Patient Name: _____ Date: _____

1. Where are your symptoms? (Describe the location(s)) _____
   _____
2. What kind of symptoms are you having? (Check all that apply)

____Burning	____Stabbing	____Cramping
____Tingling	____Aching	____Cold
____Pins & Needles	____Imbalance	____Numbness
____Electric Shock	____Skin Sensitivity	____Other: _____

3. How long have you had these symptoms? _____
4. What other therapies have you tried for your symptoms? (Medications? Therapy? Etc.) _____
   _____
5. How do the symptoms interfere with your life? _____
   _____
6. When are the symptoms worse? _____
7. Does anything make the symptoms better or worse? _____
8. Do you have diabetes or take diabetic medications/insulin? _____
9. Do you have high blood pressure or take high blood pressure medications? _____
10. Do you have high/low thyroid or take thyroid medication? _____
11. Have you ever had a heart attack, heart bypass, or heart stents placed? _____
12. Have you ever had cancer? Chemotherapy? Radiation? _____
13. Have you ever been exposed to heavy metals? (lead, arsenic, beryllium, thallium, mercury, etc) _____
    _____
14. Have you ever been exposed to solvents or chemicals? _____
15. Were you ever in the military? _____
    If so, what did you do? _____
    If so, were you exposed to Agent Orange? _____
16. What is/was your occupation? _____
17. Do you have kidney failure? _____
18. Do you have history of gout? _____
19. Do you have history of kidney stones? _____
20. Do you get cramping in your calf that gets worse with walking and relieved immediately with rest? _____
    _____
21. Has anyone in your family ever had neuropathy? _____
22. Are you or have you ever been a heavy drinker? _____
23. How much do you drink per week? _____
24. Have you ever smoked? _____ If yes, how much do/did you smoke per day? _____
25. Do you have any infectious diseases? (hepatitis, HIV, etc) _____
26. Do you have back or joint pain? _____
27. Have you ever had a blood transfusion? _____
28. Do you or have you ever taken cholesterol medication? (Crestor, Zocor, Lipitor, Etc) _____
29. Do you use an assistive device to walk? _____
30. Do you have problems buttoning a shirt or handling pills? _____
31. Have you ever had nerve testing done? _____
    If so, when and where? _____