PARKINSON'S CARE QUESTIONNAIRE

Name:_____Age: _____

Date of Birth: _____

Healthcare Provider Name:_____

What are your goals for this appointment?

_____

_____

_____

_____

List your current or most bothersome problems or symptoms:

_____

_____

_____

_____

Did you do make the changes recommended during your last visit?

_____

_____

_____

_____

(continued on back) →

Were your last treatment changes helpful? Explain: _____

_____

_____

_____

List any new medical problems or allergies since your last visit: _____

_____

_____

_____

Do you experience dyskinesia? (circle one) Yes / No

Do your medications wear off or stop working? (circle one) Yes / No

If yes, on average how long does each dose last? _____*hours*

Have you had any falls since your last visit? (circle one) Yes / No

List any changes in your living arrangements: _____

_____

_____

_____

*List prescription refills you need:*_____

_____

_____

_____

_____

(continued on following page) →

Circle any problems that you had in the past month:

Movement

Tremor	Stiffness	Slowness
Imbalance	Walking Problems	Frequent Falling
Movement Freezing	Involuntary Movements	Muscle Spasm/Cramping

Speech/Swallowing/GI

Speech Changes	Swallowing Problems	Drooling
Pneumonia	Weight Loss	Weight Gain
Nausea	Vomiting	Abdominal Pain

Bowel or Bladder/Autonomic/Other

Bladder Problems	Constipation	Diarrhea Chills/Sweats
Fatigue	Leg Swelling	Dizziness/Lightheaded
Fainting/Loss of Consciousness		Sexual Dysfunction

Cognitive/Behavioral

Anxiety	Depression	Sleep Problems
Daytime Sleepiness	Sudden Uncontrolled Sleep "Attacks"	
Vivid or Active Dreams	Memory Loss	Confusion
Hallucinations	Paranoia	
Mania Impulsive Spending, Sex, or Gambling		

Other

Fever	Chills	Fatigue
Hearing Loss	Headache	Joint Pain
Back Pain	Neck Pain	Chest Pain
Palpitations	Cough	Vision Change
Numbness/Tingling		

List any other concerns or problems that you have here: _____

_____

_____

_____