Parkinson's Ireland

NEUROLOGIST VISIT

QUESTIONNAIRE FOR MEETING YOUR NEUROLOGIST

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Hospital Attended	
Patient Name	
Physician Name (neurologist/geriatrician)	
Date and time of Appointment	
Date of last Visit	
PD Nurse Name	
Date of Meeting with PD Nurse	
GP Name & number	
Pharmacist Name & contact number	

Additional Information: _____

_____

_____

Current Medications

Name	Dose	Timing	Last changed

How have things been since the last Neurologist visit? -

_____

_____

_____

_____

Are there new medical problems since your last visit in addition to PD? e.g. any new diagnoses, hospital visits, operations etc? _____

_____

_____

_____

Since your last visit, how is your Parkinson's disease?

Better ☐ Worse ☐ Same ☐

What aspects are <u>better</u>? _____

_____

_____

What aspects are <u>worse</u>? _____

_____

_____

Is there a time of day which is better or worse regarding symptoms?

Yes ☐ No ☐ Difficult to determine ☐

Morning ☐ Afternoon ☐ Evening ☐ Night ☐

Is there an impact on you Quality of Life?

Yes ☐ No ☐

Positive ☐ Negative ☐

Details:

_____

_____

Are you participating in any other complimentary therapies?
Details:_____
_____
_____
_____
_____

Do you partake in a form of exercise?

Yes ☐ No ☐

Activity**:**_____
_____
_____
_____

Frequency of activity/exercise?

Daily/ almost daily ☐ 2-3 times per week ☐ Weekly ☐ Less frequently ☐

Duration _____ (per session)

Any additional comments: _____
_____

How Would You Describe _____ Symptoms Since Your Last Appointment?

Motor Symptoms

- Dyskinesia Better ☐ Worse ☐ Same ☐ N/A
- 'Wearing off' of medication Better ☐ Worse ☐ Same ☐ N/A
- Tremor Better ☐ Worse ☐ Same ☐ N/A
- Rigidity/ Stiffness Better ☐ Worse ☐ Same ☐ N/A
- Mobility Better ☐ Worse ☐ Same ☐ N/A
- Freezing Better ☐ Worse ☐ Same ☐ N/A
- Gait Better ☐ Worse ☐ Same ☐ N/A
- Balance/ Falls Better ☐ Worse ☐ Same ☐ N/A

Other: _____

_____

Do you mobilise with any assistance aids or require assistance?

Yes ☐ No ☐

Pain Symptoms

- Cramping Better ☐ Worse ☐ Same ☐ N/A ☐
- Dystonia Better ☐ Worse ☐ Same ☐ N/A ☐
- Muscle spasms Better ☐ Worse ☐ Same ☐ N/A ☐
- 'Wearing off' pain Better ☐ Worse ☐ Same ☐ N/A ☐
- Unexplained pain Better ☐ Worse ☐ Same ☐ N/A ☐

Other:_____

_____

Bowel/ Bladder Symptoms

- Constipation Better ☐ Worse ☐ Same ☐ N/A
- Diarrhoea Better ☐ Worse ☐ Same ☐ N/A
- Nausea/vomiting Better ☐ Worse ☐ Same ☐ N/A
- Incontinence Better ☐ Worse ☐ Same ☐ N/A
- Increased frequency (daytime) Better ☐ Worse ☐ Same ☐ N/A
- Increase frequency (nocturia- night time) Better ☐ Worse ☐ Same ☐ N/A
- Incomplete bowel/ Bladder emptying Better ☐ Worse ☐ Same ☐ N/A

Other:_____

_____

Do you take laxatives? Yes ☐ No ☐

Dietary ☐ Medications ☐ Details: _____

_____

Oral Symptoms

- Swallow Better ☐ Worse ☐ Same ☐ N/A
- Speech Better ☐ Worse ☐ Same ☐ N/A
- Volume Better ☐ Worse ☐ Same ☐ N/A
- Dry mouth Better ☐ Worse ☐ Same ☐ N/A
- Excessive drooling Better ☐ Worse ☐ Same ☐ N/A
- Episode of choking Better ☐ Worse ☐ Same ☐ N/A

Other:_____

_____

Sleep Symptoms

- Somnolence Better ☐ Worse ☐ Same ☐ N/A ☐
- Fatigue Better ☐ Worse ☐ Same ☐ N/A ☐
- Sleep apnoea Better ☐ Worse ☐ Same ☐ N/A ☐
- Vivid dreams/nightmares Better ☐ Worse ☐ Same ☐ N/A ☐
- Sleep behaviour (talking/thrashing) Better ☐ Worse ☐ Same ☐ N/A ☐
- Sleep disturbance Better ☐ Worse ☐ Same ☐ N/A ☐
- Insomnia Better ☐ Worse ☐ Same ☐ N/A ☐

Restless Legs Syndrome Better ☐ Worse ☐ Same ☐ N/A ☐

Other:_____
_____

Sensory Symptoms

- Loss of/ Altered Taste Better ☐ Worse ☐ Same ☐ N/A
- Loss of/ Altered Smell Better ☐ Worse ☐ Same ☐ N/A
- Visual Changes Better ☐ Worse ☐ Same ☐ N/A
- Eye symptoms (dry/infection) Better ☐ Worse ☐ Same ☐ N/A

Other:_____
_____

Dietary Symptoms

- Loss of appetite Better ☐ Worse ☐ Same ☐ N/A ☐
- Nausea/ Vomiting Better ☐ Worse ☐ Same ☐ N/A ☐
- Weight loss (unintentional) Better ☐ Worse ☐ Same ☐ N/A ☐
- Weight gain (unintentional) Better ☐ Worse ☐ Same ☐ N/A ☐
- 'Wearing off' post meals Better ☐ Worse ☐ Same ☐ N/A ☐

Other:_____
_____

Cognitive Symptoms

- Language Better ☐ Worse ☐ Same ☐ N/A
- Memory Better ☐ Worse ☐ Same ☐ N/A
- Thought process Better ☐ Worse ☐ Same ☐ N/A
- Concentration Better ☐ Worse ☐ Same ☐ N/A
- Multitasking Better ☐ Worse ☐ Same ☐ N/A

Other:_____
_____

Impulsive/ Compulsive Behaviour Symptoms

- Impulsive behaviour Better ☐ Worse ☐ Same ☐ N/A ☐
- Pounding Better ☐ Worse ☐ Same ☐ N/A ☐
- Gambling Better ☐ Worse ☐ Same ☐ N/A ☐
- Excessive spending Better ☐ Worse ☐ Same ☐ N/A ☐
- Hypersexuality Better ☐ Worse ☐ Same ☐ N/A ☐

Other:_____

_____

Psychological Symptoms

- Apathy Better ☐ Worse ☐ Same ☐ N/A ☐
- Anxiety Better ☐ Worse ☐ Same ☐ N/A ☐
- Depression Better ☐ Worse ☐ Same ☐ N/A ☐
- Paranoia Better ☐ Worse ☐ Same ☐ N/A ☐
- Delusions Better ☐ Worse ☐ Same ☐ N/A ☐
- Hallucinations Better ☐ Worse ☐ Same ☐ N/A☐
- Sudden onset ☐ Aware not real ☐ Frightening ☐
  Throughout day ☐ Night time ☐ Visual ☐ Auditory ☐ Sensory ☐

Other:

_____

_____

Additional Issues

Dizziness/ light head	Better ☐ Worse ☐ Same ☐ N/A ☐
Fainting Episodes	Better ☐ Worse ☐ Same ☐ N/A ☐
Hand writing/ Typing	Better ☐ Worse ☐ Same ☐ N/A ☐
Dexterity	Better ☐ Worse ☐ Same ☐ N/A ☐
Driving ability	Better ☐ Worse ☐ Same ☐ N/A ☐
Excessive sweating	Better ☐ Worse ☐ Same ☐ N/A ☐
Swelling of extremities	Better ☐ Worse ☐ Same ☐ N/A ☐
Sexual Dysfunctions	Better ☐ Worse ☐ Same ☐ N/A ☐

Other:

_____

_____

Your team

Have you been referred to any of the following health professionals since your diagnosis?

PD Nurse ☐ Physiotherapist ☐ Occupational Therapist ☐ Speech & language Therapist ☐ Dietician ☐ Psychologist/ Counselling ☐ Neuropsychiatry ☐ Other: _____

If YES to any of the above, do you need a review? _____

If NO, then consider asking your neurologist for a referral as people with PD should be assessed by all these health professionals in order to receive early intervention care.

Prescription

Suggested questions to consider in relation to prescription.

- Do you need a new/ repeat prescription?
- Have there been any medication change?
- Have there been any new medications added to regime?
- When should an improvement be noticed?
- Are there specific times recommended for new medications?
- Contact pharmacy if changes made.

Follow up appointment

- When is next appointment?
- Does appointment need to be arrange or will it be sent out by post/email

- **Date of next appointment**

Additional Questions/ Concerns

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_____

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_____

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Additional Medications

Name	Dose	Timing	Last changed