PENINSULA
PRIVATE NEUROLOGY

Parkinson's Patients - Follow up Patient Questionnaire
Diagnostic Review, Cognitive, Psychiatric and Sleep Disturbances

1. If you have not already provided your doctor with this information, please list of ALL of the medications that you are currently taking, including doses and frequency.

2. Have you fallen since you last saw the doctor? Yes No
3. Have you had any difficulty controlling your bladder or bowels? Yes No
4. Do you ever feel dizzy? Yes No
5. Have you ever seen or heard things that you know or are told are not there? Yes No
6. Do you feel sad, depressed, guilty, "low," or "blue?" Yes No
7. Have you lost interest in what is happening around you or doing things? Yes No
8. Do you have difficulty concentrating or staying focused? Yes No
9. Do you ever feel anxious, frightened, or panicky? Yes No
10. Do you have an increased interest in sex, gambling, or shopping? Yes No
11. Have any of your friends or family members been concerned about a change in your behavior? Yes No
12. Do you have problems with your memory? Yes No
13. Do you have difficulty staying awake during the day? Yes No
14. Do you have difficulty getting to sleep or staying asleep at night? Yes No
15. Do you have intense, vivid, or frightening dreams? Yes No
16. Do you talk or move in your sleep as if you are acting out a dream? Yes No
17. Do you have unpleasant sensations in your legs at night, with a feeling that you need to move your legs? Yes No
18. Do you have uncontrollable movements at times during the day? Yes No
19. Do your Parkinson's symptoms change during the day or night? Yes No
20. Which of these symptoms bothers you the most?