CHIARI & SYRINGOMYELIA QUESTIONNAIRE

FIRST NAME _____ MIDDLE _____ LAST_____

Date _____ Your age_____ The hand you use to write: right _____ left _____

CHIEF COMPLAINT

What symptom bothers you the most?

_____

How long have you noticed this?

_____

Have you ever had a head or neck injury? ____ yes ____ no

If yes, please explain _____

PRESENT ILLNESS

Do you have **headache**? Yes ____ No ____

How long have you had headaches?_____

Where in your head do you feel the pain?

_____

How long do your headaches last?

_____

What is the headache pain like? (Mark one or more) Pressure____ sharp ____ stabbing____

throbbing____ aching____ pounding____ other _____

Are your headaches worse with:

coughing Yes ____ No ____

sneezing Yes ____ No ____

straining Yes ____ No ____

laughing Yes ____ No ____

bending forward Yes ____ No ____

looking up Yes ____ No ____

Rate on a scale of 1 to 10, your most severe headache:

(Very mild) 1 2 3 4 5 6 7 8 9 10 (Most severe)

What makes your headache better?

REVIEW OF SYSTEMS: Check if you have any of these symptoms:

CONSTITUTIONAL

fatigue ____

general body weakness ____

weight loss ____

weight gain ____

fever _____

EYES

light bothers your eyes ____

blurred vision ____

double vision ____

spots in your vision ____

loss of vision ____

EAR, NOSE, MOUTH, THROAT

ringing in your ears ____

decrease or loss of hearing ____

hearing aids ____

hoarseness in your voice ____

problems swallowing ____

nose bleeds ____

seasonal allergies _____

NEUROLOGICAL

dizziness ____

vertigo (spinning) ____

numbness or pain in your face ____

problems speaking ____

problems with memory ____

problems with thinking ____

problems with balance ____

seizures ____

black out spells ____

PSYCHIATRIC

anxiety ____

depression ____

panic attacks ____

CARDIOVASCULAR

chest pain ____

palpitations (racing heart) ____

slow heart rate ____

RESPIRATORY

cough ____

shortness of breath ____

sleep apnea ____

do you use CPAP or oxygen _____

GASTROINTESTINAL

poor appetite ____

nausea ____

vomiting ____

abdominal pain ____

indigestion _____

diarrhea ____

constipation ____

GENITOURINARY

problems starting urination ____

urgency to urinate ____

wake up to urinate ____

loss of bladder control ____

MUSCULOSKELETAL

neck pain ____

arm pain _____

arm numbness _____

arm tingling ____

arm weakness ____

low back pain ____

leg weakness ____

leg pain _____

leg numbness _____

leg tingling ____

leg cramps _____

INTEGUMENTARY

rash ____

skin lesion(sores) ____

sores that don't heal ____

skin infections _____

PERIPHERAL VASCULAR

Leg/ankle swelling ____

varicose veins ____

ENDOCRINE

thyroid problems ____

night chills ____

HEMATOLOGIC/LYMPHATIC

easy bruising ____

easy bleeding ____

swelling of lymph glands ____

SLEEP

snoring ____

poor sleep ____

stop breathing at night ____

daytime sleepiness ____

Any other symptoms? _____

_____

_____

MEDICAL HISTORY

Have you ever had any of these medical illnesses?

asthma ____ cancer ____ (where/treatment _____)

diabetes ____ emphysema ____ bronchitis ____ pneumonia ____ alcoholism ____

heart disease ____ anemia ____ high blood pressure ____ liver disease ____

hepatitis ____ gastric reflux ____ ulcers ____ kidney disease/stones/infections ____

Lupus ____ seizures____ stroke or TIA ____ thyroid disease____ Chronic fatigue ____

blood clots ____ (where _____) fibromyalgia ____ tattoos _____

arthritis ____ (Rhematoid ____ osteoarthritis ____) osteoporosis ____ PTSD _____

scoliosis _____ MRSA infection _____ Shingles ____ blood transfusions _____

Insomnia_____ sleep apnea _____ drug use _____ (what kind _____)

smoking _____ (how much _____) chew tobacco _____

other medical problems _____

List **all the surgeries** you have had in the past:

_____

_____

_____

Have you ever had a problem with anesthesia ____ yes No _____

If yes, please explain _____

Have you ever had problems with wound healing _____

List **all of the medications** you currently take (include over-the -counter and supplements)

_____

_____

_____

_____

_____

Are you **allergic** to **any medications**, **latex** or **tape**? Yes ____ No ____ If yes, please list:

_____

_____

FAMILY HISTORY

Have members of your family such as parents, grandparents, brothers, sisters, or children had any serious/chronic illnesses? If so, please list:

Mother _____ Father _____

Brother _____ Sister _____

Other:_____

SOCIAL HISTORY

Are you: single ____ married ____ divorced ____ widowed _____

Do you live: alone _____ with spouse/significant other _____ in care facility _____

How many children do you have _____

Are you: a homemaker ____ employed outside the home ____ retired ____ on disability ____

If employed outside the home, what type of work? _____

What is the quality of your life now? From (worst) 1 2 3 4 5 6 7 8 9 10 (best)

Your signature: _____

Tethered Cord Syndrome Questionnaire

Yes	No	
____	____	Do you have urinary urgency?
____	____	Do you urinate often during the hours that you are awake?
____	____	How many times?
____	____	Do you have urinary incontinence?
____	____	Do you urinate at night? If yes, how many times? _____
____	____	Do you have problems starting the urinary stream?
____	____	Do you have constipation?
____	____	Do you have diarrhea?
____	____	Do you have occasional incontinence for stools?
____	____	Do you have decreased interest in sexual relations?
____	____	Do you have difficulty reaching an orgasm?
____	____	Do you have decreased sensation in your pelvic area?
____	____	Do you have low back pain?
____	____	Do you have leg pain?
____	____	Do you have numbness under the soles of your feet?
____	____	Do you keep your knees bent at night?
____	____	Do you have low back pain, leg pain, or urinary symptoms while walking up stairs?
____	____	Do you have a history of severe growing pains during childhood and adolescence?
____	____	Do you have difficulty standing longer than 60 minutes?
____	____	Do your symptoms worsen with driving or riding?
____	____	Are your symptoms worse on bumpy roads?
____	____	Have you had an injury to your spine?
____	____	Have you had any surgery on your spine?
____	____	Have you been told you have curvature of the spine (scoliosis)?
____	____	Have you been told you have spina bifida?

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