LIFEBRIDGE HEALTH BRAIN & SPINE INSTITUTE
ADULT HYDROCEPHALUS CENTER

PART ONE: ***PATIENT INFORMATION***

Name:_____

Sex:_____ Age:_____ Date of Birth:____/____/____ Social Security Number:_____

Address:_____

Home Telephone:_____ Work Telephone:_____

E-mail: _____Cell Telephone:_____

Father's Name: _____Mother's Name/Maiden Name:_____

2) Please identify a responsible family member, guardian or person we can contact:

Name:_____ Relationship:_____

Address:_____

Telephone:_____Work Number: _____

Fax Number:_____E-mail:_____

3) Please provide the following information if you reside in an Assisted Living, Rehabilitation, or Skilled Nursing Facility (along with a person we can contact):
Facility Name: _____

Contact Name:_____

Address:_____

Telephone:_____Fax Number: _____

4) Who is your primary physician?

Name:_____

Address:_____

Telephone:_____Fax Number: _____

5) What doctor referred you to us?

Name:_____

Address:_____

Telephone:_____Fax Number: _____

6) Please identify your health insurance (i.e., Medicare A/B, Blue Cross/Blue Shield, Medical Assistance, etc.):

Insurance Name	Member Number	Physician Contact Phone #	Primary/Supplemental
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL HISTORY

1) Have you ever had any of the following medical problems? Please answer all items.

	Yes	No	Describe	Date of Onset
Heart disease				◻
Heart attack				
Chest pain or angina				
Palpitation/irregular heart beat				
Pacemaker				
High blood pressure				
High cholesterol or lipids				
Lung disease				◻
Shortness of breath				
Asthma/wheezing				
Emphysema/COPD				
Bronchitis				
Kidney disease				◻
Prostate enlargement/cancer				
Bladder problem/surgery				
Hepatitis (jaundice)				◻
Hiatal hernia, reflux or ulcers				
Unexplained weight loss/gain				◻
Cancer, lymphoma, leukemia				
Anemia				◻
Sickle cell disease/trait				
Vitamin deficiency				
Abnormal blood clotting or coagulation				
Diabetes				◻
Thyroid disease				
Glaucoma				◻
Cataracts				
Macular Degeneration				
Inner ear problem/vertigo				◻
Hearing impairment/Deafness				
Stroke or TIA				◻
Paralysis				
Fainting spells				
Seizures or epilepsy				
Sleep apnea or disorder				
Depression or mood disorder				◻
Treatment by a psychiatrist				
Arthritis				◻
Back or neck surgery				
Hip, knee or foot surgery				
Lupus/Autoimmune disease				◻
HIV/AIDS, immunosuppression				
Skin disorders				◻
Syphilis				
Drug or alcohol use				

2) Please list all hospitalizations or operations: Year

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

3) Have you ever had a blood transfusion? ..... yes ☐ no ☐
4) Do you now smoke? ..... yes ☐ no ☐
If yes, indicate: Cigars ____Cigarettes ____Pipe ___*Amount smoked daily:* _____
5) Have you smoked in the past? yes ☐ no ☐ Year quit: _____
6) What is your weight? _____ pounds When did you last weigh yourself? _____
7) What is your height? (If you've become shorter, list your tallest height) ____feet ____inches

8) Have you had a hydrocephalus operation? ..... yes ☐ no ☐

Date: _____/_____/_____ Location: Head _____ Back _____

*Make and model of shunt (if known)*_____

*Surgeon:*Name:_____

Address:_____City:_____State:_____Zip:_____

Telephone:_____Fax Number: _____

9) FOR WOMEN:
a) Date of your last menstrual period: _____/_____/_____
b) Is there any possibility of your being pregnant at this time? unsure ☐ yes ☐ no ☐
c) How many vaginal (normal) deliveries have you had?_____
d) How many cesarean deliveries (C-sections) have you had?_____

10)What medical illnesses have you had that haven't been described earlier on this form?

_____

_____

_____

11) What surgical procedures have you had that haven't been described earlier on this form?

_____

_____

_____

12) List any medical illnesses associated with your family:

Grandparents_____

Parents_____

Brothers/Sisters/Children_____

If you have any additional comments or medical information you think might be helpful to us, please feel free to write in the blank space provided or attach extra pages to this form.

_____

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES

13. Are you allergic to any medicines? ..... yes ☐ no ☐

Medication	Description of allergic reaction
_____	_____
_____	_____
_____	_____

14. Are you allergic to adhesive tape? ..... yes ☐ no ☐
15. Are you allergic to iodine or seafood? ..... yes ☐ no ☐

LIVING WILL/ADVANCE DIRECTIVE

16. Do you have a living will or advance directive? ..... yes ☐ no ☐
17. Have you named a person to make medical decisions for you if you are unable to make those decisions for yourself? ..... yes ☐ no ☐
18. If so, who is that person? _____

CULTURAL/RELIGIOUS CONSIDERATIONS

19. Are there cultural or religious considerations you want us to know about as we provide care for you? ..... yes ☐ no ☐
20. If so, please explain: _____

_____

_____ Date: _____

Patient Signature

_____ Relation: _____

Signature of person (if other than patient) who filled out this form.

revised: 11/20/08

Instructions: Please complete this form no more than 7 days before your appointment. Please answer all questions; they are important for understanding your diagnosis. Do not leave any unanswered. Take your time and read each question carefully before answering it. For multiple choice questions, put an X in the box next to the **one best** answer, unless the question specifically directs you to do otherwise.

Patient's Name_____**Today's Date** _____

LBH BSI Reviewer's Initials _____

1. How long have you had the health condition for which you are seeking treatment today? Specify the length of time in number of years and months:	Number of Years _____			Number of Months _____		
WALKING AND BALANCE						
2. Do you have a problem getting in or out of a seat, walking, or maintaining your balance?	Yes ☐1	No ☐2				
3. How long has it been since you first had a problem getting in or out of a seat, walking, or maintaining your balance? Specify the length of time in number of years and months:	Number of Years _____			Number of Months _____		
4. In the past month, how often did you have a problem getting in or out of a seat (e.g. chair, toilet, sofa)?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4		
5. In the past month, how often did you misjudge the distance to a seat or fall into it when trying to sit down?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4		
6. In the past month, how often did you have a tendency to lean backwards or sideways when sitting?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4		
7. In the past month, how often did you have a problem getting in or out of a car?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4		
8. In the past month, how often did your health condition keep you from driving a car?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4		
9. In the past month, how often did you have a problem starting to walk (feeling like your feet were stuck to the floor)?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4		
10. In the past month, how often did your feet shuffle or scuff as you walked?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4		
11. In the past month, how often did you have a problem coming to a stop as you walked?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4		
12. In the past month, how often did you have a problem turning or changing direction as you walked?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4		
13. In the past month, how often did you have a problem walking on uneven surfaces, grass, or stepping over a curb?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4		
14. In the past month, how often did you hold someone's hand, or touch walls, furniture or countertops as you walked?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4		
15. In the past month, which of the following did you use to help you get around? (Mark all that apply)	None ☐1	Cane ☐2	Walker ☐3	Walker with wheels ☐4	Wheel chair ☐5	Electric Cart or Scooter ☐6
16. In the past month, how often did you fall down to the floor while getting in or out of a seat, standing, or walking?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4		

17. In the past month, how often did you nearly fall down, but kept yourself from landing on the floor?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4	
18. In the past month, how often did you avoid stairs or have a problem walking up or down stairs?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4	Not Applicable ☐5
19. In the past month, how often did you avoid ramps or have a problem walking up or down a ramp?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4	Not Applicable ☐5
20. In the past month, how often did you get a spinning sensation (vertigo)?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4	
21. Has your health condition made your handwriting shakier, smaller, or harder to read than before?	Yes ☐1	No ☐2			
22. In the past month, how often did you have trouble with your handwriting?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4	
BLADDER AND BOWEL					
23. Do you have a problem controlling your bladder?	Yes ☐1	No ☐2			
24. How long has it been since you first had a problem controlling your bladder? Specify the length of time in number of years and months:	Number of Years _____		Number of Months _____		
25. Compared to the time before your bladder problem began, do you urinate more frequently than you used to?	Yes ☐1	No ☐2			
26. In the past month, how often did you have to urinate after going to bed at night?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4	
27. In the past month, how often did you get a sudden urge to urinate and have trouble controlling it?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4	
28. In the past month, how often did you lose control of your bladder (incontinence)?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4	
29. In the past month, how often did you begin to lose control of your bladder as you were getting to the toilet, but lost only a few drops of urine and were not incontinent?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4	
30. In the past month, how often did you wear a pad or undergarment (like Depends) for incontinence?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4	
31. In the past month, how often did you leak urine when you laughed, coughed, sneezed or strained?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4	
32. In the past month, how often did you have trouble starting to urinate, or continuing to urinate once you started?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4	
33. In the past month, how often did your bladder feel completely empty immediately after you urinated?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4	
34. In the past month, how often did you have trouble telling the difference between gas and a bowel movement?	Never ☐1	Occasionally ☐2	Frequently ☐3	Always ☐4	
35. Have you ever been monitored or treated for a prostate condition (men only)?	Yes ☐1	No ☐2			
36. Have you ever been monitored or treated for a bladder condition?	Yes ☐1	No ☐2			

HEADACHE/ HEAD SENSATION	
37. Do you have headaches or the sensation that your head is full, heavy or floating?	Yes ☐1 No ☐2
38. How long have your headaches or head sensation been the way they are now? Specify the length of time in number of years and months:	Number of Years _____ Number of Months _____
39. In the past month, how often did you have headaches?	Never ☐1 Occasionally ☐2 Frequently ☐3 Always ☐4
40. In the past month, how would you rate the pain, with 0 as no pain and 10 as the worst possible pain?	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
41. In the past month, how often did you have the sensation that your head is full, heavy or floating?	Never ☐1 Occasionally ☐2 Frequently ☐3 Always ☐4
42. In the past month, how often did you have nausea or vomiting?	Never ☐1 Occasionally ☐2 Frequently ☐3 Always ☐4
43. Which of the following make your headaches or head sensation worse? (Mark all that apply)	Noise ☐1 Bright Light ☐2 Lying Down ☐3 Sitting ☐4 Standing ☐5 Coughing ☐6 Sneezing ☐7 Straining ☐8 None ☐9
44. Which of the following make your headaches or head sensation better? (Mark all that apply)	Quiet ☐1 Darkness ☐2 Lying Down ☐3 Sitting ☐4 Standing ☐5 Medications ☐6 Sleeping ☐7 Other ☐8 None ☐9
45. Have you fainted or lost consciousness as a part of the health problem for which you are seeking treatment?	Yes ☐1 No ☐2
THINKING, MEMORY AND DAILY ACTIVITIES	
46. Do you have trouble with your thinking and memory?	Yes ☐1 No ☐2
47. How long has it been since you first had a problem with your thinking and memory? Specify the length of time in number of years and months:	Number of Years _____ Number of Months _____
48. In the past month, how often did you have trouble with your memory (e.g. forgetfulness, repeating questions, trouble with learning or short-term memory)?	Never ☐1 Occasionally ☐2 Frequently ☐3 Always ☐4
49. In the past month, how often did you have trouble with orientation (e.g. getting lost, confused, disoriented, losing track of time or appointments, not recognizing familiar places or persons)?	Never ☐1 Occasionally ☐2 Frequently ☐3 Always ☐4
50. In the past month, how often did you have trouble with judgement or solving everyday problems at home (e.g. leaving water running or stove burners on; managing your medications or money; understanding explanations)?	Never ☐1 Occasionally ☐2 Frequently ☐3 Always ☐4
51. In the past month, how often did you have trouble caring for yourself (e.g. dressing, using the toilet, bathing, eating)?	Never ☐1 Occasionally ☐2 Frequently ☐3 Always ☐4
52. In the past month, how often did you have trouble organizing your schedule or daily activities?	Never ☐1 Occasionally ☐2 Frequently ☐3 Always ☐4

53. In the past month, how often did your health condition keep you from doing social, religious, or recreational activities you wanted to do?	Never ☐1 Occasionally ☐2 Frequently ☐3 Always ☐4
54. In the past month, how often did your health condition keep you from doing work you wanted to do around your home, such as cleaning, fixing a meal, gardening or yard work, or home maintenance?	Never ☐1 Occasionally ☐2 Frequently ☐3 Always ☐4
55. Are you currently working for money?	Yes ☐1 No ☐2
56. What kind of work do you, or did you do for money? Please be specific.	_____
57. Has your health condition caused you to stop working for money (job loss, disability or early retirement)?	Yes ☐1 No ☐2
58. Has your health condition caused you to change the kind of work you do for money (different job or employer)?	Yes ☐1 No ☐2
59. How often does your health condition keep you from performing your usual duties at work? If you are not presently working for money, mark "Not working".	Never ☐1 Occasionally ☐2 Frequently ☐3 Always ☐4 Not Working ☐5
60. On average, during a typical 24-hour day, how many hours do you now spend doing each of the following? a. Being inactive and not doing anything, i.e. either *sleeping or lying down*? Hours_____ b. Being active and doing things, i.e. either *on your feet or sitting*? Hours_____ **The total number of hours for a and b should equal: 24**	
61. During the past 30 days, how many days were you completely disabled by your current health condition (i.e. days when you remained in bed all or most of the time)? **Enter a number between 0 and 30**:_____	
62. How often does your health condition interfere with your usual sexual activities?	Never ☐1 Occasionally ☐2 Frequently ☐3 Always ☐4
63. In the past month, how often have you had trouble falling asleep because of your current health condition?	Never ☐1 Occasionally ☐2 Frequently ☐3 Always ☐4
64. In the past month, how often have you been awakened from sleep because of your current health condition?	Never ☐1 Occasionally ☐2 Frequently ☐3 Always ☐4
65. During the past month, how often have you felt jittery or restless?	Never ☐1 Occasionally ☐2 Frequently ☐3 Always ☐4
66. During the past month, how often have you felt anxious or tense?	Never ☐1 Occasionally ☐2 Frequently ☐3 Always ☐4
67. During the past month, how often have you felt worried or concerned about your physical health?	Never ☐1 Occasionally ☐2 Frequently ☐3 Always ☐4
68. During the past month, how often have you felt sickly or unwell?	Never ☐1 Occasionally ☐2 Frequently ☐3 Always ☐4
69. During the past month, how often have you felt sad, discouraged, or hopeless?	Never ☐1 Occasionally ☐2 Frequently ☐3 Always ☐4
70. During the past month, how often have you felt low in energy or sluggish?	Never ☐1 Occasionally ☐2 Frequently ☐3 Always ☐4
TESTING AND TREATMENT	
71. Have you had physical therapy or occupational therapy as a treatment for your health condition?	Yes ☐1 No ☐2
72. Have you been treated either with medications or surgery for Parkinson's disease?	Yes ☐1 No ☐2

73. Have you been treated with medications for dementia or Alzheimer's disease?	Yes ☐[1]	No ☐[2]			
74. Have you been treated either with medications or surgery for your bladder problem?	Yes ☐[1]	No ☐[2]			
75. Have you had spinal fluid removed as a test for your health condition (spinal tap or lumbar puncture)?	Yes ☐[1]	No ☐[2]			
76. Which of your symptoms improved (even temporarily) after spinal fluid removal? (Mark all that apply)	None ☐[1]	Walking/ Balance ☐[2]	Bladder Control ☐[3]	Thinking/ Memory ☐[4]	Headache/ Head Sensation ☐[5]
77. Have you been advised by a doctor to have either a shunt operation or endoscopic third ventriculostomy (ETV)?	Yes ☐[1]	No ☐[2]			
78. Have you had a shunt operation?	Yes ☐[1]	No ☐[2]			
79. Which of your symptoms improved (even temporarily) after the shunt operation? (Mark all that apply)	None ☐[1]	Walking/ Balance ☐[2]	Bladder Control ☐[3]	Thinking/ Memory ☐[4]	Headache/ Head Sensation ☐[5]
80. Have you had an endoscopic third ventriculostomy (ETV) operation?	Yes ☐[1]	No ☐[2]			
81. Which of your symptoms improved (even temporarily) after the ETV operation? (Mark all that apply)	None ☐[1]	Walking/ Balance ☐[2]	Bladder Control ☐[3]	Thinking/ Memory ☐[4]	Headache/ Head Sensation ☐[5]
HYDROCEPHALUS RISK FACTORS					
82. Have you ever had a head injury, concussion, or been knocked out or unconscious?	Yes ☐[1]	No ☐[2]			
83. Have you ever had meningitis (including spinal meningitis)?	Yes ☐[1]	No ☐[2]			
84. Have you ever had encephalitis?	Yes ☐[1]	No ☐[2]			
85. Have you ever had a ruptured brain aneurysm, blood vessel, arteriovenous malformation (AVM), or brain hemorrhage?	Yes ☐[1]	No ☐[2]			
86. Have you ever had a brain tumor?	Yes ☐[1]	No ☐[2]			
87. Have you ever had radiation treatments or stereotactic radiosurgery to the brain, head, face, or neck?	Yes ☐[1]	No ☐[2]			
88. Were you born with hydrocephalus or did you develop hydrocephalus before the age of 1 year?	Yes ☐[1]	No ☐[2]			
PERSONAL INFORMATION					
89. What is your gender?	Male ☐[1]	Female ☐[2]			
90. What is your date of birth?	Month		Day		Year
91. How old were you on your last birthday?					
92. Circle the highest level of formal education you have completed.					
Grade School	1	2	3	4	5 6 7 8
High School	9	10	11	12	
College	1	2	3	4	
Graduate School	Some ☐[17]	Completed ☐[18]	Highest Degree Attained: _____		

HELP ANSWERING THIS QUESTIONNAIRE

93. Did someone else help you answer or fill out any part of this questionnaire for any reason? (If No, skip to Question 96) Yes ☐[1] No ☐[2]

94. To the person who helped: (Mark all that apply) I helped answer or fill out this questionnaire because the patient…:
Had trouble writing ☐[1] Was too slow ☐[2] Didn't know the answer(s) ☐[3] Is unaware of symptom(s) ☐[4]
Denies the symptom(s) exist or thinks they aren't as bad as I think they are ☐[5] Other ☐[6] _____

95. To the person who helped: How much of the questionnaire did you help the patient with?
None of it ☐[1] Almost none of it ☐[2] Some of it ☐[3] About half of it ☐[4] Most of it ☐[5] Almost all of it ☐[6] All of it ☐[7]

MEDICATIONS

96. What medications are you currently taking? What is the dose? How often do you take each medication? Please list all prescriptions, over-the-counter medications, vitamins, or supplements you are taking.

a. Name: Dose/Strength:_____ # of pills_____	1 time a day ☐[1] 2 times a day ☐[2]	3 times a day ☐[3] 4 times a day ☐[4]	As needed ☐[5] Other_____ ☐[6]
b. Name: Dose/Strength:_____ # of pills_____	1 time a day ☐[1] 2 times a day ☐[2]	3 times a day ☐[3] 4 times a day ☐[4]	As needed ☐[5] Other_____ ☐[6]
c. Name: Dose/Strength:_____ # of pills_____	1 time a day ☐[1] 2 times a day ☐[2]	3 times a day ☐[3] 4 times a day ☐[4]	As needed ☐[5] Other_____ ☐[6]
d. Name: Dose/Strength:_____ # of pills_____	1 time a day ☐[1] 2 times a day ☐[2]	3 times a day ☐[3] 4 times a day ☐[4]	As needed ☐[5] Other_____ ☐[6]
e. Name: Dose/Strength:_____ # of pills_____	1 time a day ☐[1] 2 times a day ☐[2]	3 times a day ☐[3] 4 times a day ☐[4]	As needed ☐[5] Other_____ ☐[6]
f. Name: Dose/Strength:_____ # of pills_____	1 time a day ☐[1] 2 times a day ☐[2]	3 times a day ☐[3] 4 times a day ☐[4]	As needed ☐[5] Other_____ ☐[6]
g. Name: Dose/Strength:_____ # of pills_____	1 time a day ☐[1] 2 times a day ☐[2]	3 times a day ☐[3] 4 times a day ☐[4]	As needed ☐[5] Other_____ ☐[6]
h. Name: Dose/Strength:_____ # of pills_____	1 time a day ☐[1] 2 times a day ☐[2]	3 times a day ☐[3] 4 times a day ☐[4]	As needed ☐[5] Other_____ ☐[6]
i. Name: Dose/Strength:_____ # of pills_____	1 time a day ☐[1] 2 times a day ☐[2]	3 times a day ☐[3] 4 times a day ☐[4]	As needed ☐[5] Other_____ ☐[6]
j. Name: Dose/Strength:_____ # of pills_____	1 time a day ☐[1] 2 times a day ☐[2]	3 times a day ☐[3] 4 times a day ☐[4]	As needed ☐[5] Other_____ ☐[6]
k. Name: Dose/Strength:_____ # of pills_____	1 time a day ☐[1] 2 times a day ☐[2]	3 times a day ☐[3] 4 times a day ☐[4]	As needed ☐[5] Other_____ ☐[6]
l. Name: Dose/Strength:_____ # of pills_____	1 time a day ☐[1] 2 times a day ☐[2]	3 times a day ☐[3] 4 times a day ☐[4]	As needed ☐[5] Other_____ ☐[6]
m. Name: Dose/Strength:_____ # of pills_____	1 time a day ☐[1] 2 times a day ☐[2]	3 times a day ☐[3] 4 times a day ☐[4]	As needed ☐[5] Other_____ ☐[6]