Arrowhead Neurosurgical Medical Group, Inc.

Second Opinion Questionnaire

Please write any other pertinent information anywhere on the questionnaire within the blank spaces provided if you feel it will be helpful for us in forming your second opinion...See last page for how to send us your information.

First Name: _____ M.I. _____ Last Name: _____

Date of Birth: _____ Phone: _____

Marital Status:
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Single

Work Status:
- ☐ Employed
- ☐ Worker's Compensation
- ☐ Retired
- ☐ Disabled
- ☐ Unemployed

General Health Status
- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Dominant Hand
- ☐ Right
- ☐ Left
- ☐ Ambidextrous

Please list below any treating or referring physicians you would like to have a copy of your written second opinion report forwarded to after completion:

Treating/Referring Physician

Name: _____ Fax #: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____

Treating/Referring Physician

Name: _____ Fax #: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____

What medical problems or symptoms are you requesting a second opinion for?

Medical Problem/Symptom	Onset Date

What explicit questions do you want answered within your second opinion?

Do you now or have you ever had the following:

Heart problems	☐ Yes	☐ No	Diabetes or problems with blood sugar	☐ Yes	☐ No
Lung problems	☐ Yes	☐ No	GI problems (i.e. ulcers, hiatal hernia, gastritis)	☐ Yes	☐ No
Kidney problems	☐ Yes	☐ No	Liver disease (such as hepatitis)	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Problems with blood (i.e. clotting problems)	☐ Yes	☐ No
Any type of cancer	☐ Yes	☐ No			

Please list any other medical problems:

Please list any surgical procedures that you have had:

Surgical Procedure	Date	Facility/Hospital

SOCIAL HISTORY

Alcohol Use: ☐ Yes ☐ No How much per day? _____

Tobacco Use: ☐ Yes ☐ No How much per day? _____

Illicit Drug Use: ☐ Yes ☐ No How much per day? _____

Physical Activity: ☐ Yes ☐ No Type: _____ Days/Week: _____ Mins/Day: _____

How many times have you fallen in the last year? _____ Were you injured? ☐ Yes ☐ No

ALLERGIES & MEDICATIONS

Please list ALL prescription medications, over-the-counter medications, and vitamins/supplements that you are taking:

Medication	Dosage	# of Pills/Times Taken Per Day	Method/Route (Ex. By Mouth)

Please list any allergies you have (drugs and other substances):

Drug/Substance	Reaction

Have you ever had a reaction to any dye given for a special test? ☐ Yes ☐ No

If so, what was the test and what kind of reaction did you have?

Are you on a special diet? ☐ Yes ☐ No

If so, please specify the type of diet:

_____

_____

FAMILY HISTORY

Has anyone in your immediate family had:

High blood pressure	☐ Yes	☐ No	If so, who? _____
Heart disease	☐ Yes	☐ No	If so, who? _____
Cancer	☐ Yes	☐ No	If so, who? _____
Diabetes	☐ Yes	☐ No	If so, who? _____
Asthma	☐ Yes	☐ No	If so, who? _____
Stroke	☐ Yes	☐ No	If so, who? _____
Seizures	☐ Yes	☐ No	If so, who? _____
Migraine	■ Yes	■ No	If so, who? _____

Please list other illnesses/diseases that your immediate family members have had:

_____

_____

_____

	Alive (Current Age)	Deceased (Age)	Health Status	Cause of Death
Father				
Mother				
Brother(s)				
Sister(s)				
Children				

REVIEW OF SYSTEMS

Please check any of the symptoms you are currently experiencing:

No	Yes	Neurological/Psychiatric
☐	☐	Seizures
☐	☐	Headaches
☐	☐	Blackouts
☐	☐	Dizziness
☐	☐	Double Vision
☐	☐	Paralysis or Weakness of Limb(s)
☐	☐	Loss of Sensation
☐	☐	Loss of Balance
☐	☐	Loss of Coordination
☐	☐	Difficulty in Speaking
☐	☐	Nervousness
☐	☐	Depression
☐	☐	Difficulty in Going to Sleep
☐	☐	Early Morning Awakening
☐	☐	Difficulty Remembering Past Events
☐	☐	Difficulty Remembering Recent Events
☐	☐	Difficulty with Thinking/Problem Solving

No	Yes	Musculoskeletal
☐	☐	Muscle Pain
☐	☐	Neck Pain
☐	☐	Shoulder or Arm Pain
☐	☐	Back Pain
☐	☐	Pain Down Right Leg
☐	☐	Pain Down Left Leg
☐	☐	Painful Joints
☐	☐	Swelling of any joints
☐	☐	Redness of any joints
☐	☐	Stiffness of any joints
☐	☐	Deformities of the joints or extremities

No	Yes	Cardiovascular
☐	☐	Chest Pain, Tightness, or Squeezing
☐	☐	Shortness of Breath when Lying Down
☐	☐	Need to Sit Up to Breathe
☐	☐	Heart Racing
☐	☐	Irregular Heart Beat (Palpitations)
☐	☐	Heart Murmur
☐	☐	Swelling of the Legs
☐	☐	Varicose Veins

No	Yes	General
☐	☐	Weakness
☐	☐	Tiredness
☐	☐	Lack of Appetite
☐	☐	Excess Appetite
☐	☐	Weight Loss
☐	☐	Weight Gain
☐	☐	Chills
☐	☐	Fever
☐	☐	Night Sweats
☐	☐	Difficulty Sleeping

No	Yes	Vision/ENT
☐	☐	Decreased Ability to See
☐	☐	Blurred Vision
☐	☐	Spots Before Your Eyes
☐	☐	Pain in the Eyes
☐	☐	Difficulty in Hearing
☐	☐	Ringing in the Ears
☐	☐	Discharge from the Ears
☐	☐	Nasal Discharge (Frequent)

No	Yes	Gastrointestinal
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Diarrhea
☐	☐	Constipation
☐	☐	Heartburn
☐	☐	Abdominal Pain
☐	☐	Bright Red Blood in Stools
☐	☐	Black Stools
☐	☐	Change in Bowel Habits
☐	☐	Need for Antacids

No	Yes	Urinary
☐	☐	Urinary tract infections
☐	☐	Pain or burning on urination
☐	☐	Frequent urination – day
☐	☐	Frequent urination – night
☐	☐	Unusually large volumes of urine
☐	☐	Extreme urge to urinate

☐	☐	Leg Pain at Rest	☐	☐	Difficulty starting urinary stream
☐	☐	Leg Pain with Exertion	☐	☐	Difficulty stopping urinary stream
☐	☐	Blue/Purple Discoloration of Hands/Feet	☐	☐	Kidney stones

No	Yes	Respiratory
☐	☐	Cough
☐	☐	Wheezing
☐	☐	Asthma
☐	☐	Shortness of Breath
☐	☐	Shortness of Breath with Exertion
☐	☐	Pain in Chest During Cough/Sneeze,
☐	☐	Moving

No	Yes	Genito-Reproductive (Male)
☐	☐	History of Sexually Transmitted Disease
☐	☐	Discharge from Penis
☐	☐	Testicular Pain
☐	☐	Lumps in Testicles or Scrotum
☐	☐	Decrease in Testicular Size
☐	☐	Decreased Sexual Desire
☐	☐	Decreased Ability to Achieve Erection

No	Yes	Genito-Reproductive (Female)
☐	☐	History of Sexually Transmitted Disease
☐	☐	Decreased Sexual Drive
☐	☐	Vaginal Bleeding Since Menopause
☐	☐	Hot Flashes
☐	☐	Are You Taking Any Female Hormones?
☐	☐	Do You Ever Bleed Between Periods?

_____ What is the Date of Your Last Normal Period?

_____ What is the Date of Your Period Before That?

_____ How Far Apart Are Your Periods?

_____ How many days do they last?

_____ Is Flow Heavy, Scanty, or Normal?

_____ Age at Onset of Menstrual Periods

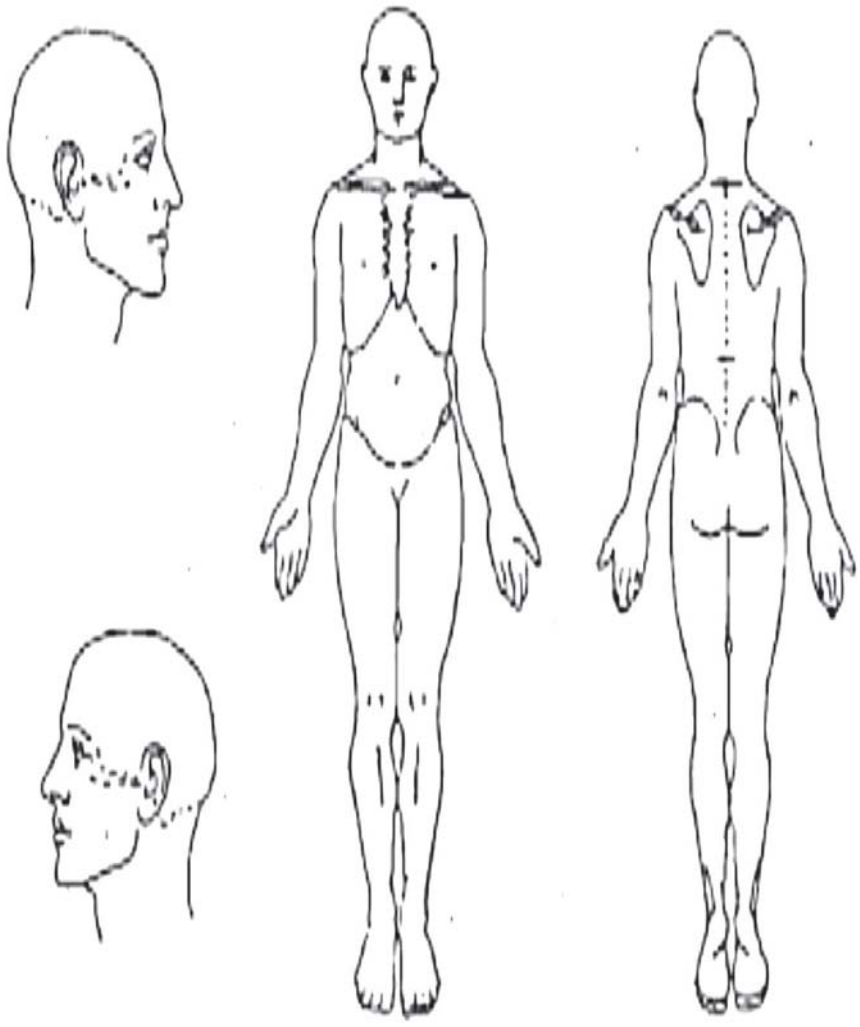
_____ Age at Which Periods Stopped (Menopause)

No	Yes	Skin
☐	☐	Dryness of Skin
☐	☐	Itching
☐	☐	Rash
☐	☐	Change in Skin Color
☐	☐	Change in Texture of the Hair
☐	☐	Change in Skin Temperature
☐	☐	Falling Out of the Hair
☐	☐	Nail Changes
☐	☐	Skin Ulcers

No	Yes	Endocrine
☐	☐	Goiter
☐	☐	Heat Intolerance
☐	☐	Cold Intolerance
☐	☐	Tremulousness of the Hands
☐	☐	Change in Pitch of the Voice
☐	☐	Increased Body Hair
☐	☐	Decreased Body Hair
☐	☐	Decrease in Breast Size
☐	☐	Loss of Periods (Not Due to Menopause)

Are you experiencing pain, numbness, or tingling at the present time? ☐ Yes ☐ No

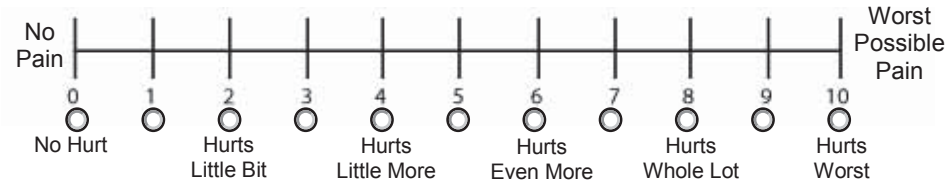
If yes, please indicate with an 'X' on the following diagram the location of your symptoms:



Severity: ☐ Constant ☐ Occasional ☐ Wakes You Up ☐ Difficulty Walking

Description: ☐ Aches ☐ Tingles ☐ Throbs ☐ Stabbing ☐ Burns ☐ Numbness

Indicate your current pain level on the following scale:



What makes your condition worse? _____

What helps your condition? _____

Other body parts affected: _____

Symptoms affected by: _____

What kind of effect do the following situations have on your symptoms?

Sitting: ☐ Increase ☐ Decrease **Standing:** ☐ Increase ☐ Decrease

Exercise: ☐ Increase ☐ Decrease **Resting:** ☐ Increase ☐ Decrease

Once you have all your required paperwork, you can collect them and send them individually, or compress them into a zip file and send them electronically to: secondopinion@anmg-ca.com

or documents can be direct mailed to: ANMG Second Opinion Program
26520 Cactus Ave, Suite A2006
Moreno Valley, CA 92555
c/o Madeline Castorena
or faxed to: above address at (951) 486-6510

PLEASE BE SURE TO PLACE PATIENT'S NAME AND DATE OF BIRTH ON ALL PAGES OF ALL FORMS IF HARD COPIES OR DISKS ARE SENT TO US. IF SENDING BY EMAIL PLEASE PLACE PATIENT'S LAST NAME AND YEAR OF BIRTH IN THE FILENAME OR DOCUMENT NAME. THIS WILL HELP PREVENT LOSS OF INFORMATION. ALSO INCLUDE PATIENT'S NAME AND YEAR OF BIRTH IN THE SUBJECT LINE OF ALL EMAILS.