Patient assessment questionnaire
Tumour

Auckland Neurosurgical Clinic Ltd

Name:	Sex: Male / Female
Address:	E-mail Address:
	Date of Birth:
Telephone number: (day) (evening)	
GP Name & Address	
Insurers name and address: Postcode:	
Occupation:	

	(Please circle)	
1. Do you have headaches?	Yes	No
2. What time of day or night do they occur?		
3. Do you suffer from nausea and vomiting?	Yes	No
4. Have you had migraine?	Yes	No
5. When did the current problems start?		
6. Do you have neck pain?	Yes	No
7. Do you have numbness in arms or legs?	Yes	No
8. Do you have weakness of the arms or legs?	Yes	No
9. Have you ever had a seizure?	Yes	No
10. If you answered yes to question 8, when was your last seizure?		
11. Have you been incontinent of urine?	Yes	No
12. Have you had any surgery in the past?	Yes	No
13. What operation/s was/were performed?		
14. Date and place of surgery:		
15. Have you had any illnesses in the past?	Yes	No

If yes please list-

Current Medication:

Aspirin	Yes	No	Plavix (Clopidogrel)	Yes	No
Warfarin	Yes	No			