Patient assessment questionnaire – Hemi-Facial Spasm

Auckland Neurosurgical Clinic Ltd

Name: Sex: Male / Female

Date of Birth: E-mail Address:

Address:

Telephone number: (day) (evening)

GP Name & Address:

Medical Insurance name and address:

Occupation:

(Please circle)

1. Have you had Spasms of the face? Which side? Yes No
   R L
2. Have you had transient weakness of the face? Which side? Yes No
   R L
3. How long did the weakness last?
4. Have you ever had speech difficulties? Yes No
5. When did the current problems start?
6. Have you ever had loss of vision? Yes No
7. Do you have high Cholesterol? Yes No
8. Do you have Diabetes? Yes No
9. If answer to questions 7 & 8 is yes, what treatment are you taking?

10. Have you ever had facial pain? Yes No
11. Have you ever had facial numbness? Yes No
12. Have you had seizures? Yes No
13. What is your weight?
14. Have you had any surgery in the past? Yes No
15. Have you had Botox Injections? Yes No
    If yes, when:-
16. What operation/s was/were performed?
17. Date and place of surgery:
18. 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			