Pre-Consultation Questionnaire

Dr. Saurabh Kamat
Neurologist & Epilepsy Specialist

This questionnaire is designed to help us gather important information before your consultation. Kindly answer the following questions to ensure we can provide the most accurate and effective care for you.

Patient Information:

- **Full Name:** _____
- **Date of Birth:** _____
- **Contact Number:** _____
- **Email Address:** _____

Neurological Symptoms:

1. **What symptoms or concerns have you been experiencing?**

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2. **When did you first notice these symptoms?**

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3. **Do you experience any of the following symptoms? (Check all that apply):**
   ☐ Seizures
   ☐ Loss of consciousness
   ☐ Headaches
   ☐ Dizziness or lightheadedness
   ☐ Memory problems
   ☐ Muscle weakness
   ☐ Numbness or tingling in the limbs
   ☐ Difficulty speaking or understanding speech
   ☐ Vision problems
   ☐ Coordination problems
   ☐ Other (please describe): _____

Dr. Saurabh Kamat

4. **Have you had any recent changes in your health or lifestyle?**
   ☐ Yes ☐ No
   If yes, please describe: _____

Previous Diagnoses & Treatments:

1. **Have you ever been diagnosed with any neurological conditions?**
   ☐ Yes ☐ No
   If yes, please provide details: _____
2. **Have you received any previous treatments for your condition?**
   ☐ Yes ☐ No
   If yes, please specify the treatment: _____
3. **Do you have a history of head injuries or trauma?**
   ☐ Yes ☐ No
   If yes, please provide details: _____

Current Medications:

1. **Are you currently taking any medications?**
   ☐ Yes ☐ No
   If yes, please list them below:

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2. **Do you have any known drug allergies?**
   ☐ Yes ☐ No
   If yes, please list them: _____

Lifestyle & General Health:

1. **Do you have any history of the following? (Check all that apply):**
   ☐ High blood pressure
   ☐ Diabetes
   ☐ Heart disease
   ☐ Stroke
   ☐ Respiratory conditions
   ☐ Kidney problems

Dr. Saurabh Kamat

☐ Cancer
☐ Other: _____

2. **Have you experienced any changes in your physical activity or lifestyle?**
   ☐ Yes ☐ No
   If yes, please explain: _____

Additional Comments:

Please include any other information you think is important for your consultation:

Patient Signature: _____
Date: _____

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