Nervous – Neurological History Questions

SECTION: 7.10
Strength of Evidence Level: 1

PURPOSE:

To gain an understanding of the patient's current issues, concerns and neurological symptoms.

CONSIDERATIONS:

1. Taking a history is the first step in determining what problems the patient is experiencing.
2. Speak slowly and distinctly.
3. Reassure the patient that the questions are for screening purposes only and are not individually indicative of a problem.
4. Phrase your question(s) in a manner that is calming and reassuring.
5. If the patient is unable to answer or understand a question, skip the question or return to it later in a rephrased manner.

EQUIPMENT:

None

PROCEDURE:

1. Ensure the patient is comfortable and establish a rapport to gain trust and put the patient at ease.
2. Explain that you are going to ask a series of questions to assess their current situation.
3. Ask the following symptom related questions:
   a. What is your current complaint?
   b. What part of the body is affected?
   c. When was the onset of the problem?
   d. Did the problem occur suddenly or gradually?
   e. Is there anything that makes the symptom(s) better or worse?
   f. Are the symptoms constant or intermittent?
   g. Have you had any recent problems with bowel or bladder incontinence?
4. Ask the following questions regarding related problems:
   a. Have you experienced weakness?
   b. Have you experienced difficulty with coordination or feeling clumsy?
   c. Have you had any visual changes?
   d. Have you lost consciousness?
   e. Have you had any nausea or vomiting?
   f. Have you had any recent headaches?
   g. Have you experienced any numbness, burning or pins-and-needles sensations?
   h. Have you experienced any change in mood, such as depression, tearfulness, anxiety, agitation, sleep problems or mania?
5. Review recent medical history:
   a. Have you had any recent infections?
   b. Have you had any recent injuries?
   c. Do you have a history of Diabetes or heart problems?
   d. For women, are you currently pregnant or have you had a recent miscarriage?
   e. Do you have any sexually transmitted diseases?
6. Social Questions:
   a. Do you have a history of smoking?
   b. Do you have a history of abuse of prescribed, over-the-counter or illicit drugs?

AFTER CARE:

1. Inform the physician/healthcare provider of any adverse findings.
2. Document in the patient's chart the findings from the history questions.

REFERENCES:

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