Name:_____ MR#: _____ Date: _____

# *DEEP BRAIN STIMULATION SURGICAL CANDIDACY EVALUATION FORM*

Referring Physician's Name: _____ Primary Care Provider's Name:_____

1. What was/were **your first movement disorder symptoms**? What did you or your family **first notice** before being diagnosed with your movement disorder?

_____

2. What **year** were you first **diagnosed** with Parkinson's Disease/ Essential Tremor/ Dystonia? _____

**3.** Which **side** of your body was **first affected**? (Circle One) **Left or Right**

4. Which of the following best describes your **current state**: (Circle One)

   a) **One** side of my body is **slightly worse** than the other side.
   b) **One** side of my body is **moderately worse** than the other side.
   c) **One** side of my body is **severely worse** than the other side.
   d) **Both** sides affect me the **same**. Can not say one side is worse.

5. Please check the box that best describes your current state:

| Symptoms (in "OFF" period except where indicated) | None | Minor | Major | Do these symptoms improve during "ON" period? | |
|---|---|---|---|---|---|
| a) Tremor | | | | Yes | No |
| b) Rigidity (stiffness) | | | | Yes | No |
| c) Dystonia (muscle cramping pain) | | | | Yes | No |
| d) Bradykinesia (slow movement) | | | | Yes | No |
| e) Gait disorder (walking difficulty, freezing) | | | | Yes | No |
| f) Postural instability (balance difficulty) | | | | Yes | No |
| g) Speech problems | | | | Yes | No |
| h) Swallowing problems | | | | Yes | No |
| i) Memory loss | | | | Yes | No |
| j) Hallucinations ***on meds*** | | | | Yes | No |
| k) Dyskinesia (extra involuntary movements) ***on meds*** | | | | Yes | No |

6. How would you rate your difference between your **best "ON" state** and your **worst "OFF" state**?

   a) Extreme b) Moderate c) Slight d) None

7. Approximately what percent of your waking daytime is **spent in the "ON" state**? _____ %

8. What **bothers you the most** about having Parkinson's disease/ Essential Tremor/ Dystonia? Describe.

_____

9. If you were to have surgery for your movement disorder, **what benefits** are you hoping for after surgery?

_____

10. Have you ever had brain surgery?
    a) No b) Yes → What procedure? _____ When? _____

11. How would you rate your level of knowledge regarding surgeries for movement disorders?
    a) Little or None b) Moderate c) Extensive

12. Where did you learn about surgeries for movement disorders?
    a) Discussion with MD b) Support Group/Seminars c) TV/Newspaper

    d) Internet e) Other: _____

13. Allergies? _____

14. When was your **last change** in medication regimen? _____

16. How long does it take for your movement disorder medications **to START** working after you take each dose?_____

17. How long does each dose of medications usually **last before its effects wear off**? _____

18. How do you **feel first thing in the morning** before you take your medications? **OFF or ON**

19. Current Medications:

| **Medication Name** | **Strength** | **Time __:__** | **Time __:__** | **Time __:__** | **Time __:__** | **Time __:__** | **Time __:__** | **Time __:__** | **Time __:__** |
|---|---|---|---|---|---|---|---|---|---|
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| | | | | | | | | | |

20. Do you have trouble with sleep? (circle one) **No** **Too sleepy** **Not enough sleep**

21. How would you rate your mood? (circle one)

**Happy** **Occasionally sad** **Often sad** **Very sad all the time**

22. Have you ever been diagnosed with any of the following?

| | No | Yes. Date of Onset or Duration | | No | Yes. Date of Onset or Duration |
|---|---|---|---|---|---|
| High blood pressure | | | Cancer | | |
| Diabetes | | | Respiratory | | |
| Heart attack | | | Bleeding problems | | |
| Heart failure | | | Leg clots | | |
| Stroke | | | Peptic ulcer disease/Reflux | | |
| Blood vessel disease | | | Renal (kidney stones) | | |
| Tuberculosis | | | Arthritis | | |
| Hepatitis | | | Other: | | |

23. FEMALES

Pregnancies, how many? _____Deliveries, how many? _____ C-sections, how many?_____

Complications of pregnancy?_____

Could you be pregnant now? **Yes** **No** Date of last normal period?_____

24. OPERATIONS: Please list surgeries you have had with date if known:

_____

_____

25. FAMILY HISTORY: List disease(s) that tend to run in the family. (diabetes, high blood pressure, heart attacks, strokes, cancer, etc…)

| Family Member | Living? | Age | Medical Disease |
|---|---|---|---|
| Mother | Yes No | | |
| Father | Yes No | | |
| Siblings: | Yes No | | |
| | Yes No | | |
| | Yes No | | |
| | Yes No | | |
| | Yes No | | |
| Children: | Yes No | | |
| | Yes No | | |
| | Yes No | | |
| | Yes No | | |

26. SOCIAL HISTORY (circle all that apply or fill in blank)

Do you smoke: Cigar? Cigarettes? Pipe? **Yes** **No** Packs per day?_____ How many years?_____

Do you drink alcohol? **Yes** **No** Type? _____ How much? _____ How often? _____

Do you use recreational drugs? **Yes** **No** Type? _____ Frequency? _____ Last used:_____

What type of work do you do, or have you done most of your life? _____

Are you retired? **Yes** **No**

What best describes your living situation?

a) Lives alone with little support b) Lives alone with close support

c) Lives with family d) Other:_____

Do you need assistance with walking?

a) Never b) Only when "OFF" c) Usually d) Always

What type of assistive device(s) do you use?

a) None b) Holding on to someone, railing, walls, or furniture

c) Cane d) Walker e) Wheelchair

27. REVIEW OF SYSTEMS: Please circle either **YES** or **NO** for each questions below:

| | | | | | |
|---|---|---|---|---|---|
| **General:** Weight gain/loss > 5lbs over the last several months?…… | Yes | No | **Respiratory:** Short of breath on exertion? | Yes | No |
| | | | Walk 2 flights of stairs without significant discomfort?…… | Yes | No |
| Loss of appetite?…… | Yes | No | Have frequent yellow or green sputum? | Yes | No |
| Fever or chills?……... | Yes | No | Cough up blood?……. | Yes | No |
| Feel weak and tired? …… | Yes | No | | | |
| **Skin:** Do you have rashes, bruises?…… | Yes | No | **Cardiovascular:** Chest pain, chest | | |
| Skin discolorations?……. | Yes | No | tightness, or angina on exertion?……. | Yes | No |
| Bleeding/easy bruising tendancy? | Yes | No | Chronic ankle swelling?…….. | Yes | No |
| **Head:** Do you have tenderness?…….. | Yes | No | Can you sleep flat in bed?…… | Yes | No |
| Lumps or masses?……. | Yes | No | Do you wake up at night short of breath? | Yes | No |
| **Eyes**: Pain or discharge?…….. | Yes | No | **Gastrointestinal:** Nausea or vomiting?…. | Yes | No |
| Change in vision?…….. | Yes | No | Diarrhea or constipation?……. | Yes | No |
| **Ears:** Hearing problems?…… | Yes | No | Black tarry stools or bloody stools?…….. | Yes | No |
| Pain or discharge?…….. | Yes | No | Heartburn or reflux?…….. | Yes | No |
| **Nose:** Frequent nose bleeds?……. | Yes | No | **Genitourinary:** Cloudy or bloody urine?.. | Yes | No |
| Trouble breathing through nose?… | Yes | No | Burning on urination?…….. | Yes | No |
| Pain or discharge?……... | Yes | No | Get up several times at night to urinate?.. | Yes | No |
| | | | Men: Hard to initiate/maintain urination? | Yes | No |
| **Mouth & Throat:** Dental disease?……. | Yes | No | **Central Nervous Systems:** Any seizures? | Yes | No |
| Hoarseness or voice changes?……. | Yes | No | Severe headaches?…… | Yes | No |
| Sore throat or other pain?…… | Yes | No | Loss of strength or sensation?…….. | Yes | No |
| Lumps, masses, discharge?……. | Yes | No | Memory changes?……. | Yes | No |