Weill Cornell Medicine
Neurological Surgery

Chiari Patient Questionnaire

Name: _____ DOB: ____ /____ /____

Height:_____ Weight: _____ ☐ Right-handed ☐ Left-handed

What is currently your most bothersome symptom? _____

_____

Please check off any of the following symptoms you are currently experiencing:

☐ **Headaches** ☐ **No Headaches**

Location of headaches:

☐ Back of the head

☐ Front of the head

☐ Side of the head ☐ Left ☐ Right

Do your headaches worsen with:

☐ Coughing ☐ Laughing

☐ Sneezing ☐ Bending Forward

☐ Straining ☐ Looking Up

How would you describe the pain of your headaches?

☐ Pressure ☐ Sharp

☐ Pounding ☐ Stabbing

☐ Throbbing ☐ Aching

Do your headaches change based on your position (i.e standing, sitting, lying down)?

☐ Yes ☐ No

If yes, do your headaches improve when lying down?

☐ Yes ☐ No

Are your headaches worse during a certain time of day?

☐ Yes, AM ☐ Yes, PM ☐ No

On a scale of 1 to 10, with 1 being very mild and 10 being the most severe, how would you rate your headaches? _____

What helps alleviate or decrease your headaches? _____

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Eyes

- ☐ Light sensitivity
- ☐ Double vision
- ☐ Loss of vision
- ☐ Blurry vision

Ears, Nose, Mouth, Throat

- ☐ Dizziness
- ☐ Vertigo (spinning)
- ☐ Ringing in your ears
- ☐ Hoarseness
- ☐ Facial pain/numbness
- ☐ Difficulty swallowing, choking
- ☐ Decrease of hearing

Neurological

- ☐ Problems with speaking
- ☐ Problems with thinking
- ☐ Problems with memory
- ☐ Neck pain
- ☐ Back pain
- ☐ Arm pain
- ☐ Arm numbness
- ☐ Arm tingling
- ☐ Arm weakness
- ☐ Leg pain
- ☐ Leg numbness
- ☐ Leg tingling
- ☐ Leg weakness
- ☐ Balance instability
- ☐ Seizures
- ☐ Black out spells

Cardiovascular

- ☐ Chest pain
- ☐ Palpitations

Respiratory

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Recurrent pneumonia

Gastroenterological

- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Poor appetite
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bowel incontinence

Genitourinary

- ☐ Problems starting urination
- ☐ Urgency to urinate
- ☐ Frequency to urinate
- ☐ Wake up to urinate
- ☐ Urinary incontinence

Sleep

- ☐ Snoring
- ☐ Long pauses of breathing during sleep
- ☐ Wake up gasping for air
- ☐ Daytime sleepiness
- ☐ Diagnosed sleep apnea (if yes, what type? _____)

Mood

- ☐ Diagnosed Anxiety
- ☐ Diagnosed Depression
- ☐ Diagnosed Panic Attacks

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Do you have a diagnosis of any of the following:

☐ Syringomyelia ☐ Scoliosis ☐ Tethered cord ☐ Spina bifida
☐ Hydrocephalus ☐ Idiopathic Intracranial Hypertension (Pseudotumor Cerebri)
☐ Ehlers-Danlos Syndrome ☐ Postural Orthostatic Tachycardia Syndrome

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How did you hear about the Chiari CARE program? _____

Who first diagnosed your Chiari Malformation? _____

What symptoms led you to have your first imaging? _____

Have you had a previous surgery for your Chiari Malformation? ☐ **Yes** ☐ **No**
If yes, who performed the surgery and when? _____

What were your main symptoms prior to surgery? _____

_____

Which symptoms were resolved_____

_____

Which symptoms decreased_____

_____

Which symptoms remained the same? _____

_____

Do you have any new symptoms post-operatively? _____

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To help us get to know more about you and your care so far with Chiari malformation, please use this space to tell us your story about your diagnosis and what brings you to seek a consultation at Weill Cornell Medicine.