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Brain and Spine Center

Chiari Patient Questionnaire

Name: _____ DOB: _____

Height:_____ Weight_____

☐ Righty ☐ Lefty

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
- ☐ Sneezing
- ☐ Straining
- ☐ Laughing
- ☐ Bending Forward
- ☐ Looking Up

How would you describe the pain of your headaches?

- ☐ Pressure
- ☐ Pounding
- ☐ Throbbing
- ☐ Sharp
- ☐ Stabbing
- ☐ Aching

On a scale of 1 to 10 (when your headaches are the most severe) how would you rate them? _____
(1 being very mild and 10 being the most severe)

What helps alleviate or decrease your headaches? _____

Eyes

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

Ears, Nose, Mouth, Throat

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

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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 spell

Cardiovascular

☐ Chest pain ☐ Palpitations

Respiratory

☐ Chronic cough ☐ Shortness of breath ☐ Hoarseness
☐ Diagnosed sleep apnea (if yes, what type? _____)

Gastroenterologist

☐ 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 ☐ Poor sleep ☐ Witnessed stop breathing at night
☐ Wake up gasping for air ☐ Fatigue ☐ Daytime sleepiness

Mood

☐ Anxiety ☐ Depression ☐ Panic Attacks

Do you have a diagnosis of any of the following:

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

Please tell us of any other medical diagnosis:

Please tell us your past surgical history:

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Please list your current medications:

_____ _____ _____ _____
_____ _____ _____ _____

Please list any allergies to medication or latex: _____

What is **currently** your most bothersome symptom? _____
_____
_____

Have you had a previous decompression surgery? ☐ Yes ☐ No

If yes, when was your surgery? _____

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 page to tell us your story in regards to your diagnosis and seeking a consultation at Weill Cornell Medicine.