

{Note this form needs to be filled out **in addition** to new patient form}

1) What body part is affected? (circle) Right hand / left hand / right leg / left leg / head / voice / jaw / trunk

2) Does the tremor worsen when you do certain tasks? Yes / No, If yes – list tasks:

3) How long have you had the tremor?

4) Did the tremor come on suddenly? Yes / No

5) What makes your tremor worse? Anxiety / nervousness / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

6) What makes your tremor better? Alcohol / Rest / Sleep / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

7) How many caffeinated drinks do you use a day?

8) Do any family members have tremors? Yes / No, If yes – Who?

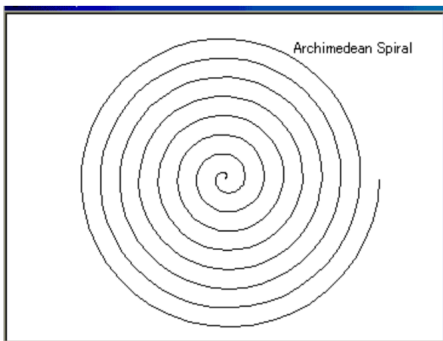
9) Have you ever had a head injury? Yes / No, if yes – give details

10) What medications has been tried for your tremors:

11) Does alcohol temporarily reduce the tremor? Yes / No / don't know

12) What tests (blood work, brain scan) have been done for your tremors:

- Physician use Only  
Parkinsonism
- Hyposmia
  - Hypomimia
  - Hypophonia
  - Drooling
  - Dysphagia
  - Depression
  - Visual Hallucination
  - Anxiety
  - Stiffness (fatigue)
  - Bradykinesia
  - Resting Tremor
  - Micrographia
  - Imbalance
  - Hunched forward
  - Shuffling gait
  - Urinary Urgency
  - Sexual Dysfunction
  - Constipation
  - RBD
  - Orthostasis
  - Melanoma



(Dr. Shah may use above image to further evaluate your tremor)

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_