EVERGREEN
HOSPITAL MEDICAL CENTER

BOOTH GARDNER PARKINSON'S CARE CENTER

DBS Returning Patient Form

NAME:	AGE:
DIAGNOSIS:	DATE OF DIAGNOSIS:

Do you have times when your medication is NOT working? ☐Yes ☐No
On average how long does each medicine dose last? _______Hours
What percentage of your waking hours do you feel it is working ("On")? ______%
What percentage of your waking hours do you feel it is not working ("Off")? ______%
At your worst (when your medication is not working or "Off") what can you no longer do? _______________
____

#Falls per week _______ New Problems ____

Indicate how severe each symptom is WHEN YOUR MEDS WEAR OFF? (Circle one)

Tremor	None	Mild	Moderate	Severe
Stiffness	None	Mild	Moderate	Severe
Slow Movement	None	Mild	Moderate	Severe
Dystonia, Muscle Spasm	None	Mild	Moderate	Severe
Walking Problems	None	Mild	Moderate	Severe
Balance or Concern about Falling	None	Mild	Moderate	Severe
Movement Freezing	None	Mild	Moderate	Severe
Dyskinesia (uncontrolled movements)	None	Mild	Moderate	Severe
"Off" Periods	None	Mild	Moderate	Severe

Indicate how severe each symptom is WHEN YOUR MEDS ARE WORKING? (Circle one)

Tremor	None	Mild	Moderate	Severe
Stiffness	None	Mild	Moderate	Severe
Slow Movement	None	Mild	Moderate	Severe
Dystonia, Muscle Spasm	None	Mild	Moderate	Severe
Walking Problems	None	Mild	Moderate	Severe
Balance or Concern about Falling	None	Mild	Moderate	Severe
Movement Freezing	None	Mild	Moderate	Severe
Dyskinesia (uncontrolled movements)	None	Mild	Moderate	Severe

Do you experience confusion ☐Yes ☐No **memory loss** ☐Yes ☐No **or hallucinations?** ☐Yes ☐No
Do you experience depression ☐Yes ☐No**, anxiety** ☐Yes ☐No **or panic attacks?** ☐Yes ☐No
List the top 3 symptoms or problems you would like either medication, deep brain stimulation surgery or programming to help?
1. ____
2. ____
3. ____

Have you had Physical Therapy, Occupational Therapy or Speech Therapy since you were here last?
If yes, when and where? What therapy helpful?
____

List All Medications

	A.M. (Morning)						P.M. (Afternoon/Evening)												A.M. (Night)					
Medication Name	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**1**	**2**	**3**	**4**	**5**

Please rate how each symptom below bothers you on a scale from 0 to 5 with 5 being the most bothersome problem (Circle one number for each problem) 0= No problem or No Concern 5 = Severe problem or Biggest Concern

Writing 0 1 2 3 4 5	Speech 0 1 2 3 4 5	Chest Pain or palpitations	☐Yes ☐No
Fine hand movement 0 1 2 3 4 5	Swallowing 0 1 2 3 4 5	Cough or sore throat	☐Yes ☐No
Bathing, Dressing 0 1 2 3 4 5	Sleep 0 1 2 3 4 5	Rash or bruising	☐Yes ☐No
Walking 0 1 2 3 4 5	Depression 0 1 2 3 4 5	Leg Swelling	☐Yes ☐No
Falls 0 1 2 3 4 5	Anxiety 0 1 2 3 4 5	Joint Pain	☐Yes ☐No
Freezing 0 1 2 3 4 5	Motivation 0 1 2 3 4 5	Heartburn or upset stomach	☐Yes ☐No
Dyskinesia 0 1 2 3 4 5	Thinking 0 1 2 3 4 5	Fatigue	☐Yes ☐No
Muscle Spasm 0 1 2 3 4 5	Hallucinations 0 1 2 3 4 5	Seizures	☐Yes ☐No
Wearing off 0 1 2 3 4 5	Pain 0 1 2 3 4 5	Hearing Loss	☐Yes ☐No
Bladder Problems 0 1 2 3 4 5	Constipation 0 1 2 3 4 5	Double or blurred vision	☐Yes ☐No
Sexual Function 0 1 2 3 4 5	Lightheaded 0 1 2 3 4 5	Headache	☐Yes ☐No