

**Patient Name** \_\_\_\_\_

Date \_\_\_\_\_

Date of Birth \_\_\_\_\_

Phone \_\_\_\_\_

**Primary Doctor**

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

**Pharmacy**

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

**What Brings You to the Doctor Today?**

- Regularly scheduled follow-up for same thing as last time
- Regularly scheduled follow-up, new problem
- Follow-up visit after doctor saw me in the hospital
- Go over test results
- Returning sooner than planned
- Haven't been here in a while
- Urgent problem that developed very recently

**Update on Other Medical Problems:**

- | <i>Yes</i>               | <i>No</i>                |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you spent any nights in a hospital since your last visit?                |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been to the ER since your last visit?                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you seen your primary doctor since your last visit?                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Did any of your doctors change any of your medications since your last visit? |

**Additional Neurological Complaints:**

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

DOB \_\_\_\_\_

Please check Yes or No

**Constitutional**

- Yes No
- Sleepiness
- Fatigue
- Weight loss

**Eyes**

- Yes No
- Blurred vision
- Double vision
- Loss of vision

**Ears, Nose, Mouth, and Throat**

- Yes No
- Loss of sense of smell
- Vertigo

**Cardiovascular and Respiratory**

- Yes No
- Chest pain
- Palpitations
- Shortness of breath

**Bladder & Sexual Function (Genitourinary)**

- Yes No
- Loss of bladder control

**Musculoskeletal**

- Yes No
- Back pain
- Muscle pain or cramps
- Neck pain

**Memory, Thinking, Mood, Psychiatric**

- Yes No
- Anxiety
- Depressed mood
- Hallucinations (seeing or hearing things)
- Memory loss

**Neurological**

- Yes No
- Confusion
- Headaches
- Incoordination
- Involuntary movements or jerking
- Lightheaded or dizzy
- Passing out
- Numbness
- Seizure
- Tremor
- Trouble swallowing
- Trouble walking
- Weakness

**Medication List**

Please list below any medications you have STARTED TAKING since your last visit.

	NAME	DOSE	FREQUENCY	REASON	SINCE
1					
2					
3					
4					
5					

Please list below any medications you have STOPPED TAKING since your last visit

	NAME	DOSE	FREQUENCY	REASON	SINCE
1					
2					
3					
4					
5					