

NEUROLOGY FOLLOW-UP PATIENT INFORMATION SHEET

Date: _____ Name: _____

What is the main problem for which you have come to see us? _____

Who is your Referring Physician? _____

Describe any changes or new neurological problems since your last visit:

Current Medications

Medication	Dose (mg)	Doses/Day

Medication	Dose (mg)	Dose/Day

Medication Allergies:

Since your last visit, have you developed any problems with the following:

Condition	Yes	No	Explain
Fever, Weight Loss, Fatigue			
Vision			
Ear, Nose, Mouth			
Heart, Circulation			
Lungs, Breathing			
Stomach, Liver, Intestines, Bowel Habits			
Kidneys, Bladder, Urination			
Muscles, Bones			
Skin			
Psychiatric			
Diabetes, Thyroid			
Blood, Glands			
Allergies			
Other			

Since your last visit, have you been hospitalized or had surgery? yes no. If yes, describe on back.

Since your last visit, have any neurological diseases developed in your family? yes no.

If yes, describe on back.

Are you currently working? yes no. Occupation (current/previous): _____

Do you currently smoke? yes no. How much? _____

Do you currently drink alcohol? yes no. How much? _____

With whom do you live? _____

If a woman, are you pregnant? yes no. If not, when was your last menstrual period?

Reviewed _____