FOLLOW-UP MEDICAL HISTORY QUESTIONNAIRE

(to be filled out by patient or family member)

Neurology Service

DATE
NAME
FMP/SSN
BIRTHDATE

Please respond to all items. If you fail to provide the required information, patient care may be compromised.

1. Do you have any **NEW** diagnoses from other healthcare providers since your last neurology visit? **[YES / NO]**
   If YES, please explain: _____

   _____

2. Have you started any **NEW** medications since your last neurology visit? **[YES / NO]**
   If YES, please list: _____

   _____

3. Have you any hospitalizations or surgeries since your last neurology visit? **[YES / NO]**
   If YES, please list: _____

   _____

4. Have you had any of the neurological symptoms listed below since you were last seen in neurology? **[YES / NO]**
   vision changes, double vision, headache, weakness, numbness, dizziness, seizures, loss of consciousness, memory loss, problems with speech or swallowing, in-coordination or difficulty walking
   If YES, please explain: _____

   _____

   _____

   _____

5. Have you had any of the symptoms listed below since you were last seen in neurology? **[YES / NO]**
   Fever or chills, weight change, hearing loss, jaw pain, neck or back pain, chest pain, shortness of breath, palpitations, fainting, skin rash, dry eyes or dry mouth, bladder or bowel problems, joint aches, muscle pain, easy bruising or bleeding, difficulty sleeping
   If YES, please explain: _____

   _____

   _____

   _____

6. Do you use tobacco or alcohol products? [YES / NO] If yes, please give amount _____

7. In the space below, please detail any other information you would like your neurologist to know regarding your visit today.

   _____

   _____

   _____

   _____