TAMPA NEUROLOGY ASSOCIATES

Date	

REVIEW OF SYSTEMS **(Please √ if you have any of the following, use ? If unsure.)**

General	Fatigue/Fever		**Gastrointestinal**	
	Weight Loss/Gain		Loss of appetite	
	Memory loss		Nausea	
Skin	Rash		Vomiting	
	Skin cancer		Blood in Stool	
Head/Neck	Headaches		Changes in Bowel habits	
	Head injury		Ulcers	
	Neck pain		**Gynecological**	
	Blurred Vision		Irregular Menses	
	Double Vision		Abnormal Vaginal bleeding	
	Hearing Loss		Pregnancy	
	Ears Ringing		Contraceptive use	
	Vertigo or Dizziness		Post Menopausal	
	Hoarseness		**Behavioral**	
	Difficulty Swallowing		Drug abuse	
Respiratory	Cough		STD	
	Asthma		HIV	
	Shortness of Breath		Unsafe sexual practices	
	TB		**Hematological**	
	Pneumonia		Transfusions	
Cardiac	Angina/Chest Pain		Anemia	
	Irregular heart beat		Cancer or Malignancy	
	Heart failure		Clotting disorder	
	Rheumatic fever		**Endocrine/Metabolic**	
Renal/Urinary	Kidney devices		Diabetes	
	Change in bladder habits		Thyroid problems	
	Blood in urine		**Bone/Joints**	
	Kidney Stones		Pain	
Emotional/Psychiatric	Depression		Swelling	
	Anxiety		Injury	
	Suicidal thoughts			
	Previous Psychological Counseling			

What is your main concern to discuss with your neurologist?

If you are 65 or older:	**YES**	**NO**
Have you fallen in past year?		
Do you have a plan of care?		
Do you have a living will?		
Do you have an advanced care plan?		
Do you have a health care surrogate?		
Do you have neuropathy?		
Do you smoke?		
Do you drink?		

TAMPA NEUROLOGY ASSOCIATES

RETURN VISIT QUESTIONNAIRE NAME | Date | |

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CHANGES TO MEDICATIONS (if any)			
Medication	Dose	Frequency	
TESTS SINCE THE LAST VISIT			
Name of test	Date	Location	

If you are 65 or older:	**YES**	**NO**
Have you fallen in past year?		
Do you have a living will?		
Do you have a power of attorney?		
Do you have a health care surrogate?		
Do you have an advanced care plan?		
Do you have neuropathy?		
Do you smoke?		
Do you drink?		

SIGNATURE

Follow up rev. 4.19.13