Maryland Neurological Center

Yearly Follow Up Questionnaire

Name:_____ Date:_____

Primary Care Physician:_____

Insurance Carrier:_____

Preferred Pharmacy:_____

Is it ok to leave a message? Yes_____ No_____

If so which phone number is the best number to use?_____

(For office use) BP_____ Pulse_____ Height _____Weight_____

What are your current symptoms:_____

_____

Please list any allergies you may have:_____

_____

Do you smoke? Yes____ No____ If yes, how much and for how long?_____

_____

How much beer or alcoholic beverages do you drink daily?_____

What is your current occupation?_____

Please list any serious illnesses or hospitalizations since your last visit:

_____

_____

If you are here for headaches, please fill this section out as well.

How many headaches do you experience per month?_____

How many headaches do you experience per week?_____

How long do they usually last?_____

On a scale of 1 to 10 how bad is the pain? (10 being the worst) _____

Do lights or sounds bother you when you have the headache?_____

Do you have nausea with the headache?_____

How many times a week do you take medication for your headache?_____

What makes your headache worse?_____

What makes your headache better?_____

Review of Systems (Please check any symptoms that apply)

Constitutional Symptoms
___Appetite Change
___Fever
___Sleep Disturbance
___Weight Loss
___Weight Gain

Skin
___Easy Bruising
___Rash
___Tick Bite(this year)

Eyes
___Double Vision
___Dry Eyes
___Glaucoma
___Episode of Visual Loss

Ear/Nose/Mouth/Throat
___Decreased sense of smell or taste
___Hearing Loss
___Hoarseness or change in voice
___Swallowing difficulty

Respiratory
___Asthma/Wheezing
___Shortness of Breath

Cardiovascular
___Chest Pain or Angina
___Fainting
___Heart Failure
___High Cholesterol
___Hypertension
___Irregular Heartbeat(palpitations)

Genitourinary
___Kidney Stones
___Loss of Blodder Control

Bones & Joints
___Arthritis
___Swollen Joints

Psychiatric
___Depression
___Hallucinations
___Anxiety
___Panic Attacks

Endocrine
___Breast Discharge
___Diabetes
___Excessive/Decreased Sweating
___Thyroid Disease

Hematologic
___Anemia
___Bleeding Disorders
___History of Blood Clots
___Past Infusions(when?)_____

Gastrointestinal
___Blood in Stool
___Constipation
___Diarrhea
___History of GI Bleeding
___Loss of Bowel Control
___Nausea or Vomiting
___Ulcer Disease

Please Review/Correct the Attached Medication List