DEPARTMENT OF NEUROLOGY Date_____
HEALTH ASSESSMENT FORM – FOLLOW UP VISIT

Name_____ **Medical Record #**_____

Since your last visit, has the problem for which you were previously seen:
☐ Improved ☐ Gone away ☐ Changed ☐ Stayed the same ☐ Worsened

If it has worsened or changed, describe how:_____
_____

Since your last visit, have you developed any new problem(s)? ☐ Yes ☐ No

If yes, describe your new problem(s):_____
_____
_____

Since your last visit, have any of your medicines changed?: ☐ Yes ☐ No

If yes, please write down any new medicines; change in dose of old medicines; or medicines you have stopped taking:_____
_____
_____

Since your last visit, have you been diagnosed with any new medical problem, psychiatric problem, or had any surgery?: ☐ Yes ☐ No

If yes, please describe:_____
_____
_____

Since your last visit, has there been any change in your marital status, occupation, smoking and drinking habits, or diet?: ☐ Yes ☐ No

If yes, please describe:_____
_____
_____

Since your last visit, has there been any change in medical problems or new diagnoses in family members or other blood relatives?: ☐ Yes ☐ No

If yes, please describe:_____
_____

PLEASE TURN PAGE OVER

Please review the list of symptoms below. Are any of these current symptoms different from what you reported during your last visit: ☐ Yes ☐ No

If yes, please check the symptoms below which are DIFFERENT from your last visit.

Constitutional (1)
- ☐ Fever / Chills / Sweats
- ☐ Weight Loss
- ☐ Tiredness / Fatigue
- ☐ Poor Appetite

Eyes (2)
- ☐ Reduced vision or blurriness
- ☐ Double vision
- ☐ Droopy eye lids
- ☐ Cataracts
- ☐ Glaucoma

Ears / Mouth / Nose / Throat (3)
- ☐ Hearing loss
- ☐ Ringing in the ears
- ☐ Vertigo
- ☐ Hoarseness
- ☐ Sinus pain
- ☐ Swallowing problem

Cardiovascular (4)
- ☐ Chest pain / Angina
- ☐ Palpitations
- ☐ Shortness of breath lying flat
- ☐ Pain in the legs with walking
- ☐ Phlebitis
- ☐ Heart attack
- ☐ High blood pressure
- ☐ High cholesterol / lipids

Respiratory (5)
- ☐ Cough
- ☐ Phlegm
- ☐ Coughing up blood
- ☐ Wheezing / Asthma

Gastrointestinal (6)
- ☐ Abdominal pain
- ☐ Nausea and / or vomiting
- ☐ Vomiting up blood
- ☐ Change in bowel movements
- ☐ Diarrhea
- ☐ Constipation

Genitourinary (7)
- ☐ Pain with urination
- ☐ Excessive urination
- ☐ Incontinence
- ☐ Blood in the urine
- ☐ Sexual problems
- ☐ Prostate problems

Musculoskeletal (8)
- ☐ Neck or back pain
- ☐ Muscle pain
- ☐ Pain / redness / swelling of a joint

Skin (9)
- ☐ Rash
- ☐ Change in sweating
- ☐ Burns

Neurologic (10)
- ☐ Headache
- ☐ Numbness or Tingling
- ☐ Muscle weakness
- ☐ Loss of consciousness
- ☐ Memory or thinking problems
- ☐ Trouble with walking or balance
- ☐ Stroke
- ☐ Seizure

Psychiatric (11)
- ☐ Psychological or Psychiatric care
- ☐ Depression
- ☐ Hallucinations
- ☐ Anxiety
- ☐ Suicidal thoughts

Endocrine (12)
- ☐ Hot / cold intolerance
- ☐ Thyroid problems
- ☐ Diabetes or sugar problem

Hematologic / Lymphatic (13)
- ☐ Anemia
- ☐ Easy bruising
- ☐ Enlarged lymph nodes

Allergic / Immunologic (14)
- ☐ Severe allergic reaction
- ☐ Frequent infections

Since your last visit, do you have NEW difficulties with any of the following activities?
(Please CHECK all that apply)

☐ Bathing	☐ Driving	☐ Cleaning
☐ Toileting	☐ Dressing	☐ Shopping
☐ Eating	☐ Taking medications	☐ Using the phone
☐ Paying Bills	☐ Cooking	☐ Traveling

Since your last visit, has your primary care physician changed? ☐ Yes ☐ No

If yes, please write the new doctor's name and address:_____

_____

THANK YOU FOR COMPLETING THIS FORM

Reviewed by Dr.:_____ Date Reviewed:_____