NEUROLOGY FOLLOW UP VISIT

Patient Name: _____ Tel. # (_____)_____ Date: _____

Date of Last Office Visit: _____ Height:_____ Weight:_____

- **PLEASE GIVE ALL RECORDS, STUDIES AND LABS TO CHECK-IN STAFF WHEN YOU ARRIVE**

1. **For Insurance Purposes: Please check if patient resides in a nursing home** ☐

2. **Has there been any worsening or improvement in your condition since your last visit? If so, in what way?**

_____

_____

_____

3. **Do you have any new problems?**

_____

_____

4. **What medications are you now taking? Name of medication and dosage (if known)**

1. _____ 4. _____ 7. _____

2. _____ 5. _____ 8. _____

3. _____ 6. _____ 9. _____

5. **Does any medication that I gave you induce unwanted side effects?**
Name of medication and side effect:

_____

_____

6. **What tests have you had since your last visit?**

_____

7. **Does any non-medicinal treatment provide benefit? (Examples would include: Physical Therapy, Biofeedback Therapy, Chiropractic, Acupuncture, etc.)**
Name of treatment: **Benefit:**

_____

8. **Referring and other doctors attending your care:**

_____

9. **Are you disabled?:** No _____ Partial _____ Total _____

10. **If you cannot work, please tell us why**:

_____

_____