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FOLLOW-UP NEURO EVALUATION

PATIENT'S PERSONAL INFORMATION

DATE:
REFERRED BY:
PATIENT NAME:
GENDER: **DATE OF BIRTH:** **SOC SEC NUMBER (last 4 numbers)::** **MARITAL STATUS:**
ADDRESS:
STREET ADDRESS:
CITY/STATE/ZIP:
CELLPHONE: _____HOME PHONE: _____EMAIL_____
NEXT OF KIN:
RELATIONSHIP TO YOU: **PHONE NUMBER:**
NAME OF PERSON TO CALL IN CASE OF EMERGENCY:
PHONE NUMBER OF PERSON TO CALL IN CASE OF EMERGENCY:

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:	
ID#:	**PHONE NUMBER:**
SUBSCRIBER NAME:	**SUBSCRIBER DATE OF BIRTH:**
SECONDARY INSURANCE NAME:	
ID#:	**PHONE NUMBER:**
SUBSCRIBER NAME:	**SUBSCRIBER DATE OF BIRTH:**

WE ARE ONLY INTERESTED IN CHANGES OVER THE PAST 2 YEARS (2021 &2022)

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SECTION II – REVIEW OF SYSTEMS PAST YEAR
Circle: Y= YES OR Circle: N= NO

SKIN:

Lumps in your skin: Y/N
Moles getting larger: Y/N
Skin rash: Y/N
Skin discoloration: Y/N
Easy bruising: Y/N
Increased sweating: Y/N

CONSTITUTIONAL:

Weight gain past year: lbs.
Weight loss past year: lbs.

EYES:

Vision change: Y/N
Glasses: Y/N
Last eye Doctor Appointment:

EAR, NOSE, THROAT:

Decreased hearing past year: Y/N
Ringing in ears: Y/N
Hoarseness: Y/N
Chronic cough: Y/N

RESPIRATORY

Asthma: Y/N
Shortness of breath: Y/N
Snoring: Y/N

CARDIOVASCULAR

Chest pain: Y/N
Irregular/rapid heart rate: Y/N
Pain in legs when walking: Y/N
Swelling of feet/ankles/heels: Y/N
Light headedness: Y/N
High blood pressure: Y/N

GASTROINTESTINAL

Change in appetite: Y/N
Explain:
Trouble swallowing: Y/N
Heartburn: Y/N
Abdominal pain: Y/N
Black stools: Y/N
Blood in stool: Y/N
Change in bowel movement: Y/N

GENITOURINARY

Wake up at night to urinate: Y/N
How many times: Y/N
Kidney infection: Y/N
Bladder infection: Y/N
Blood in urine: Y/N

MENTAL HEALTH

Mental health problems: Y/N
Tired: Y/N
Fatigued: Y/N
Nervous: Y/N
Irritable : Y/N
Depressed: Y/N
Increased stress: Y/N

MUSCULOSKELETAL

Neck pain: Y/N
Back pain: Y/N
Joint pain: Y/N
Explain:
Muscle weakness: Y/N
Explain:

Poor balance Y/N

Fall:

Other complaints:

COVID 2020 - 2022

Circle: Y= YES OR Circle: N= NO

COVID INFECTION: Y/N
COVID VACCINATION: Y/N

COVID BRAIN FOG: Y/N
Inattention: Y/N
Decision-making problems: Y/N
Language problems: Y/N
Memory problems: Y/N

LONG COVID: Y/N
Anxiety: Y/N
Depression: Y/N
Sleep Disorder: Y/N
Fatigue: Y/N

SECTION III – PAST MEDICAL & ALLERGIES PAST YEAR

Circle: Y= YES OR Circle: N= NO

INTERVAL Surgery/operations: Y/N

If yes, please list:

INTERVAL Serious medical illnesses or injuries Y/N

If yes, please list:

Are you allergic to any medications Y/N

If so, please list the medications and the reaction to the medication:

SLEEP HISTORY

Circle: Y= YES OR Circle: N= NO

What time do you go to bed:

How long does it take you to fall asleep:

Do you awaken during the night: Y/N.
Why?

If so, how often:
Total time awake each night:

Do you snore during sleep: Y/N.

Do you awaken short of breath during sleep: Y/N.

Is your mouth dry on awakening: Y/N.

Toss & turn in bed? Y/N.

Time awake in the morning:
Time out of bed after awakening:

Do you feel refreshed on awakening: Y/N.

Do you feel tired on awakening: Y/N.

Do you nap during the day Y/N.

At what time:	**For how long:**	**Minutes/Hours**
Any other sleep problems:		

SECTION IV – SOCIAL HISTORY PAST YEAR

Circle: Y= YES OR Circle: N= NO

CURRENT EXERCISE: Y/N

Activity:	**How often**

CURRENT SMOKING Y/N

Cigarettes /day: #	**Cigars /day: #**

CURRENT ALCOHOL: Y/N

How much per day:

CURRENT DIET:

Regular: Y/N	**Diabetic:** Y/N	**Cholesterol lowering:** Y/N	**Weight Reduction:** Y/N

CURRENT CAFFEINE:

Caffeinated beverage # cups (8 oz. /day =

ILLEGAL DRUG USE PAST YEAR: Y/N

Name of drug(s)_____

MEDICATION HISTORY

(Include all over-the-counter drugs including vitamins, antacids, and aspirin products)

NAME OF MEDICATION	DOSE	FREQUENCY	CONDITION

NAME OF OVER-THE-COUNTER DRUGS	DOSE	FREQUENCY	CONDITION

DRUG ALLERGIES

PHARMACY **FAX** **PHONE:**

SECTION V --- FAMILY HISTORY CHANGES OVER THE PAST 2 YEARS