Mid Maryland Neurology

GENERAL Follow-Up

Name: ______________________ **Date:** ______________

PATIENT SECTION:

Reason for today's visit:

Since your last visit how have your problems *changed*?

Problems	*Status of the problem*			*Comment*
	❑ Better	❑ Worse	❑ Unchanged	
	❑ Better	❑ Worse	❑ Unchanged	
	❑ Better	❑ Worse	❑ Unchanged	
	❑ Better	❑ Worse	❑ Unchanged	

Review of Systems: Check any *positives*.

❑ Blurred Vision	❑ Dizziness	❑ Headache	❑ Numbness	❑ weight gain >5lb
❑ Chest Pain	❑ Anxiety	❑ Insomnia	❑ Tremor	❑ weight loss >5lb
❑ Confusion/Memory loss	❑ Depression	❑ Muscle pain	❑ Rash	❑ Fatigue
❑ Constipation	❑ Diarrhea	❑ Nausea	❑ Weakness	

❑ Have you experienced involuntary episodes of crying and/or laughing that are exaggerated or contrary to how you you felt at the time

PRIME-MD PHQ-2

Over the past 2 weeks have you often been bothered by any of the following problems?	Yes	No
1. Feeling down, depressed or hopeless?	❑	❑
2. Little interest or pleasure in doing things?	❑	❑

Current Medications(list all meds)**:**

Name	*Dose schedule*	*Comments/ Side effects*

PHYSICIAN SECTION:

Vitals:	BP:	Pulse:	Temp:	Weight:

NOTES: