Mid Maryland Neurology

GENERAL Follow-Up Visit

Name: ______________________ **Date:** ______________

PATIENT SECTION:

Main reason for visit:

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

Problem	*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 ❑ Anxiety ❑ Muscle pain ❑ Rash ❑ Fatigue

❑ Chest Pain ❑ Depression ❑ Nausea ❑ Weakness

❑ Confusion ❑ Headache ❑ Numbness ❑ weight gain >5lb

❑ Dizziness ❑ Insomnia ❑ Tremor ❑ weight loss >5lb

❑ Other Symptoms:

Current Medication:

Name	*Dose/How taken*	*Is it effective?*	*Side effects/Comments*
		❑ Yes ❑ No ❑ Not sure	
		❑ Yes ❑ No ❑ Not sure	
		❑ Yes ❑ No ❑ Not sure	
		❑ Yes ❑ No ❑ Not sure	
		❑ Yes ❑ No ❑ Not sure	
		❑ Yes ❑ No ❑ Not sure	

Testing: Check the tests you have has since your last visit.

❑ Blood Work ❑ Carotid Study ❑ CT ❑ EEG ❑ MRI ❑ Other__________

Comments:

PHYSICIAN SECTION:

Vitals:	BP:	Pulse:	Temp:	Weight:

NOTES: