Be Mobile Neurology

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Established Patient Questionnaire

(Please complete prior to each visit)

Date_____Name_____

Your Goals for Today's Visit:

1. _____

2. _____

New Neurologic Problems or Issues you would like to discuss? ☐No ☐ Yes

_____

_____

Since Your Last Visit:

1. Have your neurologic symptoms changed? ☐Better ☐Worse ☐Same

Why? _____

2. Falls? ☐Yes ☐ No. If Yes: were you injured in the fall ☐Yes ☐ No

If injured, explain_____

Received medical care or hospitalized? ☐Yes ☐ No

If yes, explain_____

3. Hospitalizations? ☐Yes ☐ No If Yes: Date of Hospitalization_____

Reason_____

4. New Tests such as imaging, EEG, sleep study, cognitive or psychiatric evaluation? ☐Yes ☐ No

Results_____

_____

5. New Lab Tests? ☐Yes ☐ No Results: _____

_____

6. Medication Changes

	Medication	Dosage	Frequency	Date
1.				
2.				
3.				
4.				

7. Please List Any Changes in (if none, leave blank): ☐ Living Situation_____
☐Career/Job_____ ☐Smoking_____ ☐Alcohol_____
☐Family History_____

Review of Symptoms {only check if a new symptom(s) or problem(s) since last visit}
Constitutional: ☐Poor Energy ☐Fever ☐Fatigue ☐Change in Appetite ☐Excessive Daytime Sleepiness ☐Problems with Nighttime Sleep
Eyes: ☐Blurred Vision ☐Double Vision ☐Unexplained Decreased Vision
Ears/Nose/Mouth/Throat: ☐Difficulty Smelling ☐Hoarse Voice ☐Ringing in Ears ☐Difficulty Swallowing ☐Discharge from Ears ☐Sinus Discharge ☐Hearing Impaired, if yes ☐Hearing Aid

Neurologic: ☐Headache ☐Memory Loss ☐Slowed or Trouble Thinking ☐Tremors ☐Dizziness/Vertigo ☐Falling/Walking Difficulty ☐Poor Balance ☐Loss of Coordination ☐ Numbness/Tingling
Psychiatric: ☐Depressed ☐Anxious ☐Panic Attack ☐Hallucinations ☐Mood Changes

Hematologic/Lymph: ☐Enlarged Lymph Nodes ☐Increased Bleeding ☐Increased Bruising ☐Limb Swelling

Heart/Cardiovascular: ☐Passing Out/Fainting ☐High Blood Pressure ☐Abnormal heart/rhythm ☐Angina/Chest Pain ☐Heart Attack ☐Blood Clots (DVT) for all of above when_____

Lungs/Respiratory: ☐Hyperventilation ☐Cold, Cough or Bronchitis now ☐Shortness of Breath ☐Wheezing

Allergy/Immunology: ☐Frequent or unusual Infections_____

Gastrointestinal - Stomach/Intestines/Liver: ☐ Constipation ☐Abdominal Pain ☐Reflux/Heartburn ☐Frequent/Persistent Nausea ☐Diarrhea ☐Blood in Stool ☐Incontinence of Stool

Genitourinary: ☐Increased Urge to Urinate ☐Increased Frequency of Urination ☐Urinary Retention ☐Incontinence of Urine ☐Blood in Urine ☐Miscarriages ☐Difficulty with Sexual Functioning

Skin: ☐Hair Loss ☐Rashes ☐Changing Moles ☐Ulcers

Endocrine: ☐Recent Weight Gain_____lbs ☐Recent Weight Loss_____lbs ☐Increased Thirst ☐Heat or Cold Intolerance ☐Irregular Menses

Bones/Joints/Muscles: ☐Joint Pain ☐Joint Swelling ☐Weakness ☐Back/Neck Pain ☐Muscle Cramps

Financially Responsible Party: ☐Self ☐Other_____

If you have a new physician please provide*(Please note, we email or fax notes and request the patient provide contact information)*: Physician Name_____

Physician email or fax number_____

Patient Name_____

Patient Signature_____

Date_____