

NEUROLOGY AND SLEEP MEDICINE, P.C.

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NAME: _____

DATE: _____

Family Doctor: _____

DOB: _____

What changes have you had in your neurological condition(s) since your last visit?

Are you having any adverse reactions to medications prescribed by our office? () No () Yes.

Explain: _____

Do you smoke? () No () Yes, _____ packs per day

Do you drink? () No () Yes, _____ ounces of _____ per day

CURRENTLY, are you experiencing: (please check)

____ Arm weakness (left / right / both)

____ Involuntary Movements

____ Awakenings from sleep

____ Leg weakness (left / right / both)

____ Bladder / bowel incontinence

____ Loss of sensation

____ Bladder urgency / frequency

____ Muscle pain

____ Clumsiness

____ Ringing in ears

____ Confusion

____ Speech changes

____ Dizziness

____ Vision changes

____ Fatigue

____ Weight loss / gain

____ Headache

Other: _____

Have you been diagnosed with a new medical condition or undergone surgery since your previous evaluation? _____

Have you had testing performed since your last evaluation? _____