Seton Brain & Spine Institute
NEUROLOGY
A member of the Seton Family of Hospitals

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Follow up Visit Questionnaire

Patient Name: _____Date of Service:_____

Name of PCP if changed since your last visit_____

Initial here if you DO NOT want a copy of today's note sent to this physician_____

Reason for your Follow up visit today:_____
_____
_____
_____
_____
_____

Medications

Please list your updated medications and doses. If you brought your medication list, attach to this questionnaire:

_____
_____
_____
_____
_____
_____
_____
_____
_____

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Please circle the symptom or symptoms that you currently have or have had in the last six months. If you don't have any symptoms, please circle no symptoms.

General:
Fever
Chills
Weight loss
Weight gain
Fatigue
Syncope
Excessive sweating
Depression
Anxiety
No Symptoms

Eyes/Ears:
Change in vision
Blurred vision
Double vision
Loss of hearing
Ringing of the ears
Earaches
No Symptoms

Throat/Sinus:
Difficulty swallowing
Sore throat
Nasal pain
Nose bleeds
No Symptoms

Neck:
Neck stiffness
Swollen lymph nodes
No Symptoms

Pulmonary:
Shortness of breath
Dry cough
Productive cough
Pneumonia
No Symptoms

Cardiac:
Chest pain
Palpitations
Hypertensions
Heart murmur
No Symptoms

Vascular/Hematologic:
Swollen legs
Blood clots
Anemia
Easy bruising or bleeding
Transfusions
No Symptoms

GI:
Stomach pain
Constipation
Diarrhea
Hepatitis
No Symptoms

Urinary:
Frequency
Incontinence
Infections
No Symptoms

Musculoskeletal:
Muscle aches
Joint pain
No Symptoms

Neurological:
Headache
Seizure
Stroke
Weakness
Tremor
Imbalance
Falls
No Symptoms

Other:
_____
_____
_____
_____