MRN _____

COLUMBIA NEUROLOGY SPECIALISTS: F/U PATIENT INFORMATION SHEET

Please fill out completely and leave nothing blank.

Date _____ **Name** _____**Age** _____ **DOB** _____ **Gender** _____ **Handedness** _____

Your Problem _____ **Height** _____ **Weight** _____

New medical/surgical problems (check if ***none*** ☐)

_____ _____

_____ _____

_____ _____

Systems review/Are you ***currently*** experiencing (please check ***none*** or ***applicable symptoms*** in each row)

General:	☐none	☐fever	☐chills	☐ malaise	☐fatigue	☐wt loss	☐wt gain
Eyes:	☐none	☐eye pain	☐vision loss	☐eyes red	☐eye discharge	☐dry eyes	☐itchy eyes
ENT:	☐none	☐earache	☐hearing loss	☐nosebleed	☐nasal discharge	☐sore throat	☐hoarseness
Cardiac:	☐none	☐chest pain ☐leg pain when walking	☐palpitations	☐rapid heartbeat ☐leg swelling	☐slow heartbeat		
Respiratory:	☐none	☐short of breath ☐short of breath on lying		☐wheezing ☐awakening short of breath	☐cough	☐short of breath on exertion	
GI:	☐none	☐abd pain	☐nausea/vomit	☐constipation	☐diarrhea	☐heartburn	☐bloody stool
Urology:	☐none	☐painful urination ☐painful periods		☐incontinence ☐ discharge	☐difficulties urinating ☐sexual dysfunction		☐pelvic
Muscle:	☐none	☐joint pain	☐joint swelling	☐joint stiffness	☐limb pain	☐limb swelling	
Dermatolgy:	☐none	☐rash	☐skin lesion	☐itching			
Neurology:	☐none	☐confusion	☐seizures	☐dizziness	☐limb weakness	☐ difficulty walking	
Psychiatry:	☐none	☐Suicidal thoughts ☐personality change		☐anxiety ☐sleep difficulties	☐depression	☐hallucinations	
Endocrine:	☐none	☐hot flashes	☐excessive urination		☐generalized weakness	☐hot/cold intolerance	
Hematology:	☐none	☐easy bruising/bleeding		☐swollen glands			
Other:	☐none	_____					

Medications (name, dose, pills/day. If ***none***, please check here ☐. Please list ***all*** medications even if unchanged.)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medication Allergies (if ***none***, please check here ☐) _____

List any new neurological diseases in your family _____

Working: ☐ yes ☐ no. Occupation _____ With whom do you live? _____

Do you smoke? ☐ yes ☐ no. How much? _____ Do you drink alcohol? ☐ yes ☐ no. How much? _____

Do you currently use any recreational drugs? ☐ yes ☐ no. Which one(s)? _____

Do you currently exercise? ☐ yes ☐ no. How much? _____ If a woman, are you pregnant? ☐ yes ☐ no.

Patient signature _____

For office use only:

FU _____ Testing _____

Provider review _____