

The Neurology Center

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REVIEW OF SYMPTOMS

NAME: _____ ACCOUNT: _____ DATE: _____

Please check if you have currently or recently had any of the following:

GENERAL

- Fever
- Chills
- Night Sweats
- Weight Gain
- Weight Loss
- Loss of Appetite
- Hot Flashes

HEAD AND NECK

- Blurred Vision
- Double Vision
- Seeing Spots
- Poor Hearing
- Nasal Congestion
- Sinus Congestion
- Nose Bleeds
- Mouth Sores/Fever Blisters
- Sore Throat
- Dental Problems
- Other

RESPIRATION

- Cough
- Sputum Production
- Coughing Up Blood
- Shortness of Breath
- Shortness of Breath with Exertion
- Wheezing
- Other

CIRCULATION

- Chest Pain
- Heart Pounding, Racing, or Skipping
- Swollen Feet
- Other

DIGESTION

- Trouble Swallowing
- Nausea
- Vomiting
- Heartburn
- Diarrhea
- Constipation
- Hemorrhoids
- Blood in Stool
- Black Stools
- Other

URINARY

- Burning With Urination
- Increased Frequency
- Up At Night to Urinate
Number of Times _____
- Dark or Bloody Urine
- Kidney Stones
- Bladder Infection
- Incontinence
- Other

PROSTATE

- Difficulty Urinating
- Prostate Problems
- Last Prostate Exam

- Other

MUSCULOSKELETAL

- Arthritis
- Bone or Joint Pain
Which Ones? _____
- Back Pain
- Swollen Joints
- Other

NEUROLOGIC

- Seizures
- Headaches
- Dizzy Spells
- Numbness
- Weakness
- Forgetfulness
- Confusion
- Balance
- Other

SKIN

- Rash
- Change in a Mole
- Lumps or Bumps
- Itching
- Change in Color
- Bruising
or Bleeding
- Other

EMOTIONS

- Nervousness
- Depression
- Anxiety
- Trouble Sleeping
- Other

PAIN

- Location
- Severity (Rank from
1 to 10, if 10 is the worst)
- How long does it last? _____
- What makes it better or
worse? _____

Please Provide us with the Name and Telephone number of your local Pharmacy:

Name: _____

Address: _____

Tel: _____

Physician's Signature: _____