



THE NEUROLOGY CENTER

ESTABLISHED PATIENT REVIEW OF SYSTEMS FORM

Service Date:	Attending Physician
Patient Name:	Height:
Date of Birth:	Weight:

Have you been diagnosed with any medical conditions or had surgery since your last visit? _____

Has any family member been diagnosed with a neurologic illness since your last visit? _____

Are there any changes in your medications or supplements since your last visit? If yes please list:

(Please circle if you have currently or recently had any of the following.)

<p><u>ALLERGY/IMMUNE</u> Ear fullness Hives Itchy eyes Nasal/Seasonal allergies Runny nose Scratchy throat Sinus congestion Recurrent infections</p> <p><u>ENDOCRINOLOGY</u> Cold intolerance Excessive sweating Excessive thirst Heat intolerance Hot flashes Urinating frequently</p> <p><u>OPHTHALMOLOGY</u> Blurring of vision Cataracts Diminished vision Double vision Loss of vision Pain</p>	<p><u>CARDIOLOGY</u> Chest pain Irregular heart beat Leg swelling Pain in leg while walking Palpitations Shortness of breath</p> <p><u>ENT/RESPIRATORY</u> Change in voice Chronic cough Coughing up blood Difficulty swallowing Frequent nasal allergies Frequent nosebleed Hearing loss Ringing in ears Sinus problems Sore throat</p> <p><u>PSYCHOLOGY</u> Anxiety Depression Hallucinations Suicidal thoughts</p>	<p><u>CONSTITUTIONAL</u> Fatigue Fever Loss of appetite Night sweats Weakness Weight gain in past 12 months Weight loss in past 12 months</p> <p><u>GASTROENTEROLOGY</u> Abdominal pain Blood in stool Constipation Diarrhea Difficulty swallowing Heartburn Nausea Vomiting <i>Date of last colonoscopy?</i> _____</p> <p><u>RLS/PLM ROS</u> Restless leg symptom Restless sleep</p>	<p><u>CPAP ROS</u> Dry mouth Mouth venting Nasal congestion Nasal dryness Snoring with CPAP in place</p> <p><u>MUSCULOSKELETAL</u> Back pain Joint pain Joint swelling Leg cramps Shooting arm pain Shooting leg pain Arthritis Bone or Joint Pain - Which ones? _____</p> <p><u>UROLOGY</u> Blood in urine Difficulty urinating Erectile or other sexual dysfunction Recurrent urinary tract infection</p>	<p><u>DERMATOLOGY</u> Rash Hives Lumps</p> <p><u>NEUROLOGY</u> Balance difficulty Dizziness Headache Loss of sensation in specific body area Loss of strength in specific body area Memory problems Numbness Seizure Tingling Tremors Trouble with coordination</p>
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Physician Signature: _____ **Date:** _____