CTNC Central Texas Neurology Consultants

Diseases of the Brain, Spine, Nerves and Muscles

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FOLLOW UP PATIENT VISIT

Movement Disorders

Patient Name: _____ Date: _____ Age: _____

Referring Physician: _____ Family Physician (PCP): _____

Handedness: ☐ Left ☐ Right ☐ Both

Reason for Appointment:

MEDICATIONS: (please include any over-the-counter medications and supplements). If you already have a list prepared, please attach a copy. You do not need to rewrite it.

MEDICINE	DOSE	# OF TIMES PER DAY

REVIEW OF SYSTEMS:
Please check the "Yes" or "No" box to indicate if you currently have any of the following symptoms:

	YES	NO		YES	NO		YES	NO
Weight loss			Shortness of breath			Depression		
Fatigue			Constipation			Hallucinations		
Blurred Vision			Diarrhea			Numbness		
Double Vision			Frequent urination			Loss of sense of smell		
Nasal discharge			Urinary urgency			Loss of sense of taste		
Hoarseness			Loss of control of urine			Rashes		
Difficulty chewing			Bleeding disorders			Skin changes		
Difficulty swallowing			Problems with easy bruising			Abnormal moles		
Chest pain			Joint pain			Intolerance to cold		
Fainting spells			Muscle pain			Excessive thirst		
Cough			Anxiety			Enlarged lymph nodes		

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