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 any of the following.)

ALLERGY/IMMUNE
Ear fullness
Hives
Itchy eyes
Nasal/Seasonal allergies
Runny nose
Scratchy throat
Sinus congestion
Recurrent infections

ENDOCRINOLOGY
Cold intolerance
Excessive sweating
Excessive thirst
Heat intolerance
Hot flashes
Urinating frequently

OPHTHALMOLOGY
Blurring of vision
Cataracts
Diminished vision
Double vision
Loss of vision
Pain

CARDIOLOGY
Chest pain
Irregular heart beat
Leg swelling
Pain in leg while walking
Palpitations
Shortness of breath

ENT/RESPIRATORY
Change in voice
Chronic cough
Coughing up blood
Difficulty swallowing
Frequent nasal allergies
Frequent nosebleed
Hearing loss
Ringing in ears
Sinus problems
Sore throat

PSYCHOLOGY
Anxiety
Depression
Hallucinations
Suicidal thoughts

CONSTITUTIONAL
Fatigue
Fever
Loss of appetite
Night sweats
Weakness
Weight gain in past 12 months
Weight loss in past 12 months

GASTROENTEROLOGY
Abdominal pain
Blood in stool
Constipation
Diarrhea
Difficulty swallowing
Heartburn
Nausea
Vomiting
Date of last colonoscopy?

_____

RLS/PLM ROS
Restless leg symptom
Restless sleep

CPAP ROS
Dry mouth
Mouth venting
Nasal congestion
Nasal dryness
Snoring with CPAP in place

MUSCULOSKELETAL
Back pain
Joint pain
Joint swelling
Leg cramps
Shooting arm pain
Shooting leg pain
Arthritis
Bone or Joint Pain - Which ones?_____

UROLOGY
Blood in urine
Difficulty urinating
Erectile or other sexual dysfunction
Recurrent urinary tract infection

DERMATOLOGY
Rash
Hives
Lumps

NEUROLOGY
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

Physician Signature:_____ **Date:**_____