Coastal Neurology
Follow-up Visit Questionnaire

Patient Name: _____

Why are you being seen today?

_____
_____

Please List CURRENT Medications with Dosages and Frequency

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please List NEW Medical Problems, Hospitalizations, or Surgeries Since Your Last Visit

_____	_____	_____	_____
_____	_____	_____	_____

Are you <u>currently</u> experiencing any of the following problems? (Check where appropriate)

	Yes	No		Yes	No
Headaches	☐	☐	**Visual Changes**	☐	☐
Dizziness	☐	☐	**Hearing Loss**	☐	☐
Vertigo	☐	☐	**Problems Swallowing**	☐	☐
Balance Problems	☐	☐	**Unexplained Weight Loss**	☐	☐
Memory Loss	☐	☐	**Fainting**	☐	☐
Attention Problems	☐	☐	**Liver Trouble**	☐	☐
Sleep Problems	☐	☐	**Kidney Trouble**	☐	☐
Numbness In Hands or Feet	☐	☐	**Bladder Incontinence**	☐	☐
Neck Pain	☐	☐	**Bowel Incontinence**	☐	☐
Back Pain	☐	☐	**Depression**	☐	☐
Are you Pregnant?	☐	☐	**Thoughts of Suicide**	☐	☐