RIVERHILLS NEUROSCIENCE
Division of Neurology

Returning Patient Questionnaire

Patient Name _____ **Date** _____

Date of Birth _____

Phone _____

Primary Doctor

Name: _____

Address: _____

City, ST, ZIP: _____

Phone #: _____

Fax #: _____

Pharmacy

Name: _____

Address: _____

City, ST, ZIP: _____

Phone #: _____

Fax #: _____

Describe New Problem (if applicable) in 10 words of less:

What Brings You to the Doctor Today?:

- ☐ Regularly scheduled follow-up for same thing as last time
- ☐ Regularly scheduled follow-up, new problem
- ☐ Follow-up visit after doctor saw me in the hospital
- ☐ Go over test results
- ☐ Returning sooner than planned
- ☐ Haven't been here in a while
- ☐ Urgent problem that developed very recently

Misc. Personal Information:

Yes	No	
☐	☐	Any recent change in where you live, or whom you live with?
☐	☐	Any recent change in you work duties (retirement, new job, disability, etc)?
☐	☐	Any recent change in how much you smoke or drink?

Update on Other Medical Problems:

Yes	No	
☐	☐	Have you spent any nights in a hospital since your last visit?
☐	☐	Have you been to the ER since your last visit?
☐	☐	Have you seen your primary doctor since your last visit?
☐	☐	Did any of your doctors changes any of your medication since your last visit?

Patient Name _____ DOB _____

Please check Yes or No to ALL below

Constitutional

Yes	No	
☐	☐	Excessive daytime sleepiness
☐	☐	Fatigue
☐	☐	Fevers
☐	☐	Low energy
☐	☐	Trouble *getting* to sleep
☐	☐	Trouble *staying* asleep
☐	☐	Weight gain
☐	☐	Weight loss

Eyes

Yes	No	
☐	☐	Blurred vision
☐	☐	Double vision
☐	☐	Loss of vision

Ears, Nose, Mouth, and Throat

Yes	No	
☐	☐	Loss of sense of smell
☐	☐	Hearing loss
☐	☐	Ringing in your ears

Cardiovascular and Respiratory

Yes	No	
☐	☐	Chest pain
☐	☐	Palpitations
☐	☐	Shortness of breath

Gastrointestinal

Yes	No	
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Heartburn
☐	☐	Nausea
☐	☐	Vomiting

Bladder & Sexual Function (Genitourinary)

Yes	No	
☐	☐	Discomfort and burning
☐	☐	Loss of bladder control
☐	☐	Loss of desire for sex
☐	☐	Menopause (women)
☐	☐	Trouble with erection (men)
☐	☐	Urgency to urinate

Skin

Yes	No	
☐	☐	Change in hair or nails
☐	☐	Change in skin color
☐	☐	Itching
☐	☐	Rash

Neurological

Yes	No	
☐	☐	Confusion
☐	☐	Falling down
☐	☐	Headaches
☐	☐	Incoordination
☐	☐	Involuntary movements or jerking
☐	☐	Lightheaded or dizzy
☐	☐	Loss of consciousness/fainting/passing out
☐	☐	Numbness
☐	☐	Seizure or convulsion
☐	☐	Spinning or vertigo
☐	☐	Tingling
☐	☐	Tremor
☐	☐	Trouble speaking
☐	☐	Trouble walking
☐	☐	Weakness
☐	☐	Trouble swallowing

Musculoskeletal

Yes	No	
☐	☐	Back pain
☐	☐	Joint pain or swelling
☐	☐	Muscle pain or cramps
☐	☐	Neck pain

Endocrine

Yes	No	
☐	☐	Heat or cold intolerance
☐	☐	Increased thirst
☐	☐	Loss of hair

Memory, Thinking, Mood, Psychiatric

Yes	No	
☐	☐	Anxiety
☐	☐	Depressed mood
☐	☐	Hallucinations (seeing or hearing things)
☐	☐	Memory loss

Hematologic (blood) and lymphatic

Yes	No	
☐	☐	Anemia
☐	☐	Easy bruising or bleeding
☐	☐	Slow to heal after cuts

Allergic and Immune

Yes	No	
☐	☐	Allergic reaction to medicine or x-ray dye

SIGN HERE

Signature of Patient **Date**

Signature of person completing form **Date**
(if not patient)

Patient Name _____ DOB _____

Returning Patient Medication List

Please bring to your appointment and list below any medications you have STARTED TAKING since your last visit.

- Include over-the-counter medications, dietary supplements, etc.

	NAME	DOSE	FREQUENCY	REASON	SINCE
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					

Please list below any medications you have **STOPPED TAKING** since your last visit

	NAME	DOSE	FREQUENCY	REASON	SINCE
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

RIVERHILLS NEUROSCIENCE

Important

To assist us in providing the best patient care, please bring a complete and up-to-date **list of your medications** to every visit with your physician.

We need to keep an accurate record of the medicines you are **currently** taking.