

Neurology Institute of Melbourne

Follow Up Visit Information

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Please indicate any changes to your personal information in the space below (address, phone number, insurance etc...)

Have you had any of the following since your last visit? Circle each Item appropriately.

Do you have any NEW symptoms involving the following? Please list.

Fainting                      more    less    same    n/a

Eyes \_\_\_\_\_

Dizziness                    more    less    same    n/a

Ears \_\_\_\_\_

Lightheadedness        more    less    same    n/a

Nose \_\_\_\_\_

Loss of Memory            more    less    same    n/a

Head \_\_\_\_\_

Tremors                     more    less    same    n/a

Lungs \_\_\_\_\_

Seizures                    more    less    same    n/a

Heart \_\_\_\_\_

Numbness                  more    less    same    n/a

Urinary Tract/

Neck Pain                  more    less    same    n/a

Kidneys \_\_\_\_\_

Back Pain                  more    less    same    n/a

Digestive System/

Gait Problems             more    less    same    n/a

Liver \_\_\_\_\_

Balance Problems        more    less    same    n/a

Male /Female

Speech Difficulties      more    less    same    n/a

Organs \_\_\_\_\_

Headache                  more    less    same    n/a

Bones \_\_\_\_\_

Other \_\_\_\_\_ more    less    same    n/a

Skin \_\_\_\_\_

Please list any new surgeries since last visit.