Kingston Neurological Associates

Follow-Up Visit Patient Questionnaire

Your Name:____ Today's Date:_____/_____/_____

Purpose of today's visit:

Please list any medications started since you were last seen in this office. Include dose and frequency

Since your last visit, did you change the dose of any medication? If so, why?

Since your last visit, were any medications discontinued? If so, why?

Since your last visit, has there been any change in your general medical status?

Since your last visit, have you undergone any surgery/procedure/x-rays or other testing?

Since your last visit, has there been any **change** in symptoms described below? (please circle if yes)

nausea or vomiting	sexual problems	limb pain	anxiety	difficulty swallowing
fever	chest pain	joint pain	depression	dizziness
weight gain	palpitations	bone problems	headaches	vertigo
weight loss	shortness of breath	neck pain	memory problems	clumsiness
change in appetite	allergies	low back pain	agitation	unsteadiness
visual change	constipation	muscle pain	confusion	weakness
hearing loss	diarrhea	skin problems	hallucinations	numbness
ear ache	abdominal pain	bleeding or bruising	personality changes	tingling
ringing in ears	black or tarry stools	anemia	difficulty speaking	stiffness
cough	blood in stools	fatigue	change in taste	slowness
sore throat	problems urinating	difficulty sleeping	change in smell	shaking