HARTFORD NEUROLOGY, LLC
Patient F/U Questionnaire Form

Patient Name: _____ Date:_____

Date of Birth: _____ Age: _____ Current Weight: _____Height: _____

SYSTEM REVIEW

Check off symptoms that apply to you

CONSTITUTIONAL SYMPTOMS
- Recent weight changes ☐
- Fever ☐
- Fatigue ☐

EYES
- Visual loss ☐
- Glaucoma ☐

EARS/NOSE/MOUTH/THROAT
- Hearing loss ☐
- Ringing in the ears ☐

CARDIOVASCULAR
- Heart trouble ☐
- Lightheaded or dizziness ☐
- Chest pain or angina ☐
- Palpitations ☐
- Swelling in the feet or ankles ☐

RESPIRATORY
- Chronic or frequent cough ☐
- Spitting up blood ☐
- Shortness of breath ☐
- Asthma or wheezing ☐
- COPD ☐
- Sleep Apnea ☐

GASTROINTESTINAL
- Rectal bleeding or blood in stool ☐
- Abdominal pain or heartburn ☐
- Peptic ulcer disease ☐

GENITOURINARY
- Painful urination ☐
- Frequent urination ☐
- Change in force of stream when urinating ☐
- Incontinence or dribbling ☐
- Nephrolithiasis (kidney stones) ☐
- Hematuria (blood in urine) ☐
- Recurrent Urinary Tract Infection ☐

MUSCULOSKELETAL
- Joint pain or swelling ☐
- Muscle Weakness ☐
- Muscle pain or cramps ☐
- Low Back pain ☐
- Neck Pain ☐

INTEGUMENTARY/SKIN and BREAST
- Rash or itching ☐

NEUROLOGICAL
- Frequent or recurring headaches ☐
- Convulsions or seizures ☐
- Numbness or tingling sensations ☐
- Tremors ☐
- Paralysis ☐
- Stroke ☐
- Head injury ☐
- Difficulty walking ☐
- Memory loss ☐
- Daytime sleepiness ☐

PSYCHIATRIC
- Depression ☐
- Anxiety ☐

ENDOCRINE
- Thyroid disease ☐
- Diabetes ☐

HEMATOLOGICAL/LYMPHATIC
- Anemia ☐
- Past blood transfusion ☐

Allergies? _____

_____

_____

HEALTH MAINTENANCE

Have you had a Mammogram? YES / Date: _____ NO **Have you had a Colonoscopy**? YES / Date: _____ NO

Pneumonia Vaccine YES / Date: _____ NO **Eye Exam:** YES / Date: _____ NO

Flu Vaccine YES / Date: _____ NO Dilated?: YES NO

Normal?: YES NO

MEDICATION LIST: ***if you have a list we can attach a copy for your convenience***

Medication Name & MG (or MCG / ML)	Dosage (# of pills taken)	Frequency (how often taken)