ATLANTA NEUROLOGY, P.C.

Returning Patient Form

Name: _____ DOB: _____ Date: _____
Change in Preferred Pharmacy: □ Yes □ No _____

What is your chief complaint?

Compared to your last visit are your symptoms better, worse, or unchanged? *Elaborate.*

Any changes in your other medical problems? □ Yes □ No

Any new allergies? □ Yes □ No

Any changes in your family's medical history? □ Yes □ No

Any changes in your social history? □ Yes □ No

Medications: List all current medications. Name of medication, dosage, and frequency taken.

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

Tobacco Use: □ Never □ Former □ Current □ How Much? _____
Alcohol Use: □ Never □ Former □ Current □ How Much? _____

Review of Symptoms: *Mark any symptoms you are currently experiencing.* **Height: _____Weight: _____**

Constitutional: □ Daytime sleepiness □ Fever □ Insomnia □ Snoring □ Weight gain □ Weight loss	Respiratory: □ Cough □ Shortness of breath	Neurological: □ Difficulty swallowing □ Falls □ Headache □ Memory trouble □ Numbness □ Slurred speech
Skin: □ Rash	Gastrointestinal: □ Appetite change □ Bloody stool	Psychological: □ Anxiety □ Depression
HENT: □ Dizziness/vertigo □ Double vision □ Ringing in ear(s) □ Vision loss	Genitourinary: □ Bladder incontinence □ Loss of sexual interest	Hematological: □ Excessive bruising □ Swollen lymph nodes/glands
Cardiovascular: □ Chest pain □ Fainting □ Palpitations	Musculoskeletal: □ Muscle pain □ Painful or swollen joints □ Weakness	Women's Health: Breastfeeding? □ Yes □ No Pregnant? □ Yes □ No Using birth control? □ Yes □ No