ATLANTA NEUROLOGY
RETURNING PATIENT INFORMATION

Name:_____ Date of Birth_____ Date: _____
Referring Physician: _____ Primary Physician: _____

What is your chief complaint? _____
Compared to your last visit are your symptoms better, worse or unchanged? In what ways?

_____
_____
_____
_____

Any changes in your other Past Medical Problems?

_____
_____

MEDICATIONS

Pill Name:	Pill Dose (mg)	How often?	Pill Name:	Pill Dose (mg)	How often?

ANY NEW ALLERGIES?

Any change in your Family's Medical History?

Any changes in your Social History (Marital Status, Job, Exercise, Alcohol Use)?

TOBACCO USE: ☐ NEVER? ☐ FORMER? ☐ CURRENT? HOW MUCH?

REVIEW OF SYSTEMS

WHAT IS YOUR CURRENT HEIGHT ___FT ___IN, AND WEIGHT _____LBS

MARK ANY SYMPTOMS YOU CURRENTLY HAVE:

Constitutional:
☐ Weight Loss over 5#
☐ Weight Gain over 5#
☐ Fevers
☐ Daytime Sleepiness
☐ Snoring
☐ Insominia

Skin:
☐ Rash

ENT:
☐ Headaches
☐ Vertigo
☐ Double Vision
☐ Visual Loss

Cardiovascular:
☐ Chest Pain
☐ Fainting
☐ Palpitations

Respiratory:
☐ Cough
☐ Shortness of Breath

Gastrointestinal:
☐ Appetite Change
☐ Bloody or Dark Stools

Genitourinary:
☐ Urinary Incontinence
☐ Loss of Sexual Interest

Musculoskeletal:
☐ Muscle Pain
☐ Weakness

Neuro/Psych:
☐ Memory Trouble
☐ Anxiety/Depression
☐ Numbness
☐ Slurred Speech
☐ Difficulty Swallowing

Heme/Endocrine:
☐ Swollen Lymph Nodes
☐ Swollen Glands

Other (explain):