

## 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:

<p><b>Constitutional:</b>          _____ Weight Loss over 5#          _____ Weight Gain over 5#          _____ Fevers          _____ Daytime Sleepiness          _____ Snoring          _____ Insomnia</p> <p><b>Skin:</b>          _____ Rash</p> <p><b>ENT:</b>          _____ Headaches          _____ Vertigo          _____ Double Vision          _____ Visual Loss</p>	<p><b>Cardiovascular:</b>          _____ Chest Pain          _____ Fainting          _____ Palpitations</p> <p><b>Respiratory:</b>          _____ Cough          _____ Shortness of Breath</p> <p><b>Gastrointestinal:</b>          _____ Appetite Change          _____ Bloody or Dark Stools</p> <p><b>Genitourinary:</b>          _____ Urinary Incontinence          _____ Loss of Sexual Interest</p>	<p><b>Musculoskeletal:</b>          _____ Muscle Pain          _____ Weakness</p> <p><b>Neuro/Psych:</b>          _____ Memory Trouble          _____ Anxiety/Depression          _____ Numbness          _____ Slurred Speech          _____ Difficulty Swallowing</p> <p><b>Heme/Endocrine:</b>          _____ Swollen Lymph Nodes          _____ Swollen Glands</p> <p><b>Other (explain):</b>          _____</p>
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