ATLANTA NEUROLOGY
RETURNING PATIENT INFORMATION

Name:____ Date of Birth________________ Date: __________________
Referring Physician: _____________________________ Primary Physician: ___________________________________
E-Mail Address: ________________________________ Phone (c) ____________ (h) ____________ (w) ____________

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? _________________
ALCOHOL 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
_____ Insomnia

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):