MRN _____

COLUMBIA NEUROLOGY SPECIALISTS: F/U PATIENT MEDICAL HISTORY

Please fill out ***completely*** and leave ***nothing*** blank

Date _____ Name _____ Age _____ DOB _____ Gender _____ Handedness _____

Your Problem _____ **New Med/Surg Problems** (if ***none***, check here ☐) _____

_____

Systems review/Are you ***currently*** experiencing (please check ***none*** or ***applicable symptoms*** in each row)

General	☐none	☐fever	☐chills	☐ malaise	☐fatigue	☐wt loss	☐wt gain
Eyes	☐none	☐eye pain	☐vision loss	☐eyes red	☐eye discharge	☐dry eyes	☐itchy eyes
ENT	☐none	☐earache	☐hearing loss	☐nosebleed	☐nasal discharge	☐sore throat	☐hoarseness
Cardiac	☐none	☐chest pain ☐leg pain when walking	☐palpitations	☐rapid heartbeat	☐slow heartbeat	☐leg swelling	
Resp	☐none	☐short of breath ☐short of breath on awakening	☐short of breath on exertion	☐wheezing	☐short of breath on lying ☐cough		
GI	☐none	☐abd pain	☐nausea/vomit	☐constipation	☐diarrhea	☐heartburn	☐bloody stool
GU	☐none	☐painful urination ☐painful periods		☐incontinence ☐ discharge	☐difficulties urinating ☐sexual dysfunction		☐pelvic pain
Muscle	☐none	☐joint pain	☐joint swelling	☐joint stiffness	☐limb pain	☐limb swelling	
Derm	☐none	☐rash	☐skin lesions	☐itching			
Neur	☐none	☐confusion	☐seizures	☐dizziness	☐limb weakness	☐ difficulty walking	
Psych	☐none	☐suicidal thoughts ☐personality change		☐anxiety ☐sleep difficulties	☐depression	☐hallucinations	
Endo	☐none	☐hot flushes	☐excessive urination		☐overall weakness	☐hot/cold intolerance	
Heme	☐none	☐easy bruising/bleeding		☐swollen glands			
Other	☐none	_____					

Medications (including prescription over the counter, vitamins, supplements, herbs, etc; ***do not*** write ***no change***)
If ***none***, check here ☐

Name	Dose	Pills/day	Name	Dose	Pills/day
_____			_____		
_____			_____		
_____			_____		
_____			_____		
_____			_____		
_____			_____		
_____			_____		
_____			_____		

Medication Allergies (if ***none***, check here ☐) _____

List neurological diseases in your family (if ***none***, check here ☐) _____

Working ☐ yes ☐ no Occupation _____ With whom do you live _____
Do you currently smoke ☐ yes ☐ no How much _____ Do you currently drink alcohol ☐ yes ☐ no How much _____
Do you currently exercise ☐ yes ☐ no How much _____ If a woman, are you pregnant ☐ yes ☐ no

Patient signature _____ **Provider Signature** _____ **Date** _____