Revisit Review of Systems **Patients Name**_____

Reason for Revisit_____

Please complete the following by completely filling in the appropriate circles.

Weight Loss of >10 lbs	O Yes	O No	Any injuries over the last year	O Yes	O No
Weight gain of >10 lbs	O Yes	O No	Do you have pain	O Yes	O No
Difficulty speaking	O Yes	O No	If so, where? _____		
New weakness/numbness	O Yes	O No	How severe on scale of 1 to 10? _____		
New or different headache	O Yes	O No	WEIGHT _____		
Loss of consciousness	O Yes	O No	HEIGHT: _____		
Difficulty walking	O Yes	O No	**Please circle one:**		
Visual changes	O Yes	O No	Smoker		
Hearing change	O Yes	O No	Current every day smoker		
Palpitations	O Yes	O No	Current some day smoker		
Chest Pain	O Yes	O No	Former smoker		
Racing of your heart	O Yes	O No	(How Long: O < 1month		
Shortness of Breath with exercise	O Yes	O No	O 1 -3 months		
Bowel incontinence	O Yes	O No	O 3 -6 months		
Urine incontinence	O Yes	O No	O 6 -12 months		
Joint pain	O Yes	O No	O 1-5 years		
Sleep disturbances	O Yes	O No	O 5 -10 years		
Rash	O Yes	O No	O >10 years)		
Heat intolerance	O Yes	O No	Never a smoker		
Cold intolerance	O Yes	O No	Current Status Unknown		
Abnormal bleeding or bruising	O Yes	O No	Unknown if ever smoked		
Tobacco use	O Yes	O No	**Flu Shot for Current year**	O Yes	O No
Any falls over the last year	O Yes	O No	**Living Will**	O Yes	O No
			Durable Power of Attorney for Healthcare	O Yes	O No

Since last visit: **Decision Maker**_____

ANY INPATIENT HOSPITALIZATIONS IN PAST 30 DAYS O Yes O No

Any Labs O Yes O No Any X-Rays O Yes O No

Please contact our office if you answer **Yes to either of the next two questions concerning your appointment.**

Currently in **Nursing Home** O Yes O No Currently under the care of **Hospice** O Yes O No

NEUROLOGY ASSOCIATES, LLP
389 Mulberry Street - Suite 200
Macon, Georgia 31201-7904
478 – 743-9123

NAME:_____ **DATE:**_____

PLEASE LIST YOUR CURRENT MEDICATIONS (strength and dosages), INCLUDING ANY OVER-THE-COUNTER MEDICATIONS. FOR YOUR SAFETY, THIS FORM HAS TO BE COMPLETED AT EVERY VISIT.

PLEASE LIST ANY DRUG, FOOD OR ENVIRONMENTAL ALLERGIES.

PLEASE LIST YOUR PHARMACY NAME AND LOCATION, INCLUDING LOCAL AND/OR MAIL ORDER.

ARE YOUR UNDER THE CARE OF HOSPICE? _____ YES _____ NO

DO YOU RESIDE IN A NURSING HOME? _____ YES _____ NO