**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_**

**Have there been any changes to your medications since your last appointment? No / Yes**

**Are you having any problems taking your medications as prescribed? No / Yes**

If yes, why? (Circle) Cost Side effects Ineffective Trouble remembering medications

**Have you had any Emergency Room visits or Hospitalizations since your last visit? No / Yes**

If **YES,** was it related to a neurological problem such as headache, seizures, or MS? **No / Yes**

**Are you currently smoking? No / Yes**

**In the last month, have you had any of the following symptoms? (Circle the symptom)**

**General:** Weight loss Weight Gain Dizziness

**Eyes:** Blurred Vision Loss of Vision Double Vision

**Ear/Nose/Throat:** Tinnitus Hearing Loss Trouble Swallowing Trouble speaking

**Lungs:**  Shortness of Breath Do you use oxygen? No / Yes Do you use a CPAP? No / Yes

**Cardiovascular:** Dizziness with standing High Blood Pressure Swelling of Feet

**GI:** Diarrhea Constipation Nausea or Vomiting

**Urinary:** Urinary tract infection Can’t urinate Incontinence (accidents) Blood in Urine Kidney Stones

**Musculoskeletal:** Neck pain Low Back Pain Joint Pain Muscle Aches

**Neurologic:** Numbness or Tingling Weakness Balance problems Unsteady while walking

Falls Nervous About Falling Trouble Concentrating Memory Loss Hallucinations

**Headaches:** How many days of headache have you had in the last month? \_\_\_\_\_\_

How many days per month do you get a severe headache that limits your ability to function? \_\_\_\_\_\_\_

On average how many days in the past month did you take acute (as needed) medication? \_\_\_\_\_\_\_\_\_\_

**Seizures:** When was your last seizure? \_\_\_\_\_\_\_ How many seizures have you had since your last visit? \_\_\_\_\_\_\_

Have your seizures changed since your last visit? No / Yes If yes, how? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any injuries because of your seizures? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep:** Can’t Fall Asleep Can’t Stay Asleep Snoring Acting out Dreams Sleep Apnea

**Mental health:** Depression Anxiety Irritability

**Skin/Heme:** Rash Easy Bleeding Easy Bruising

**Endocrine:** Cold intolerance Heat Intolerance Diabetes

**Reproductive:** Decreased libido **Currently pregnant?** No /Yes Are you **planning** on becoming pregnant? No/ Yes