INNOVATIVE NEUROSURGERY ASSOCIATES

Follow-up Visit

Patient Name: _____ Visit Date _____/ _____/ _____

Purpose of todays visit

_____

_____

_____

Conservative treatments (physical therapy, medically directed home exercise regimen, opioids & narcotics, injections etc.)

_____

_____

Changes in medications

_____

Review of Systems (check all that apply)

General/constitutional

- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Fatigue
- ☐ Weight loss _____
- ☐ Weight gain _____

Ophthalmologic

- ☐ Blurred vision
- ☐ Vision loss

ENT

- ☐ Ringing in ear
- ☐ Sore throat
- ☐ Sinus congestion
- ☐ Hearing loss

Endocrine

- ☐ Chng in hat/ring/shoe sz.
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Excessive hunger

Respiratory

- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheeze

Cardiovascular

- ☐ Chest Pain
- ☐ Pounding in chest
- ☐ Swelling in feet/ankles

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Incontinence of stool

Hematology

- ☐ Easy bruising
- ☐ Easy bleeding
- ☐ Swollen lymph nodes

Genitourinary

- ☐ Frequent urination
- ☐ Urinary urgency
- ☐ Painful urination
- ☐ Urinary incontinence
- ☐ Sexual dysfunction

Musculoskeletal

- ☐ Weakness
- ☐ Difficulty walking
- ☐ Neck pain
- ☐ Back pain
- ☐ Joint pain/swelling
- ☐ Use of cane/walker

Skin

- ☐ Itching
- ☐ Rash
- ☐ Skin lesion

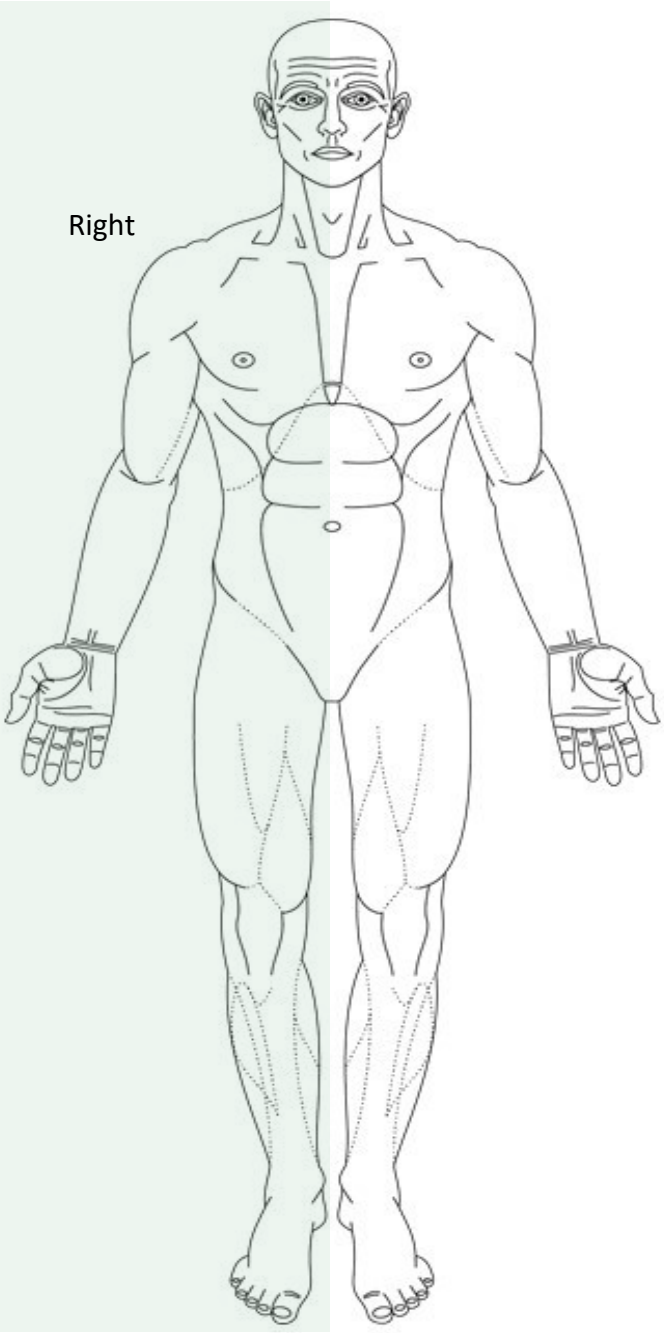
Neurologic

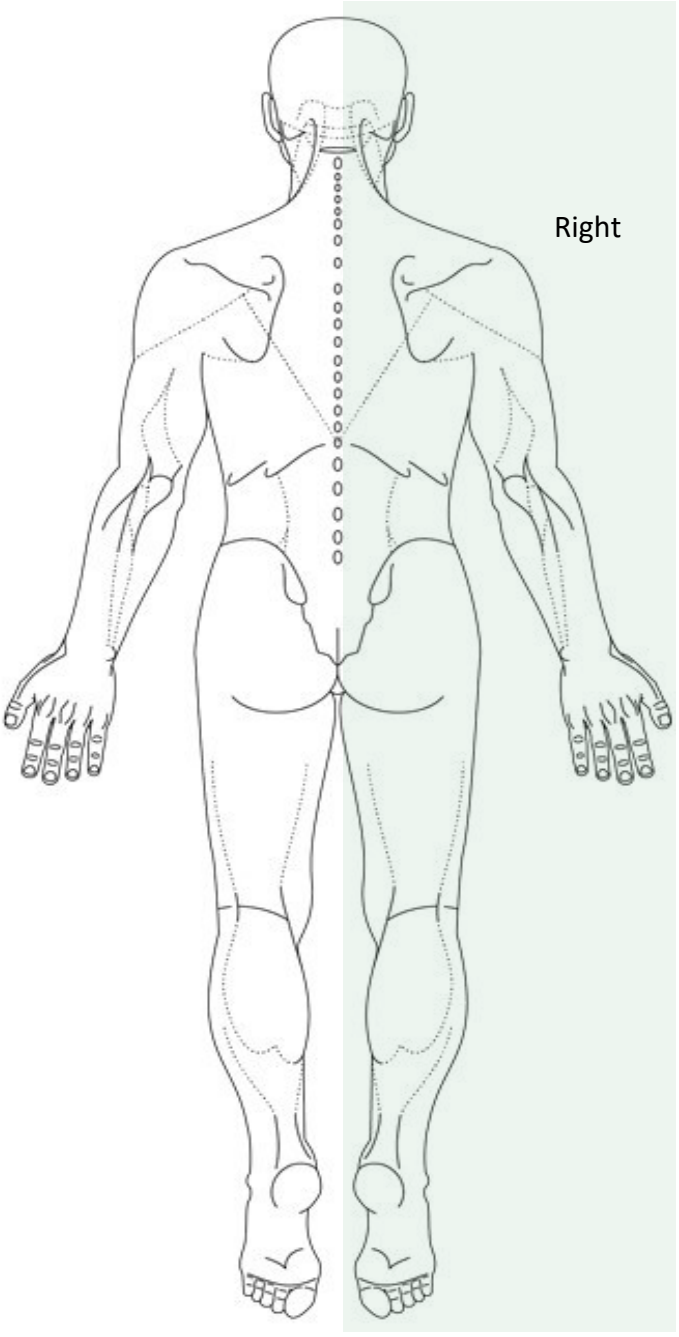
- ☐ Shooting pain
- ☐ Numbness
- ☐ Tingling
- ☐ Poor balance
- ☐ Headaches
- ☐ Confusion
- ☐ Memory loss
- ☐ Speech difficulty
- ☐ Seizures

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty sleeping

Name: _____ Visit Date _____/ _____/ _____





Could you please describe how you are doing today and any changes in your overall health since your last visit?

Feel free to make marks on the drawings to help us better understand your situation.

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