INNOVATIVE NEUROSURGERY ASSOCIATES

Follow-up Visit

Patient Name: _____ Visit Date _____/ _____/ _____

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

Purpose of todays visit

_____

_____

_____

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

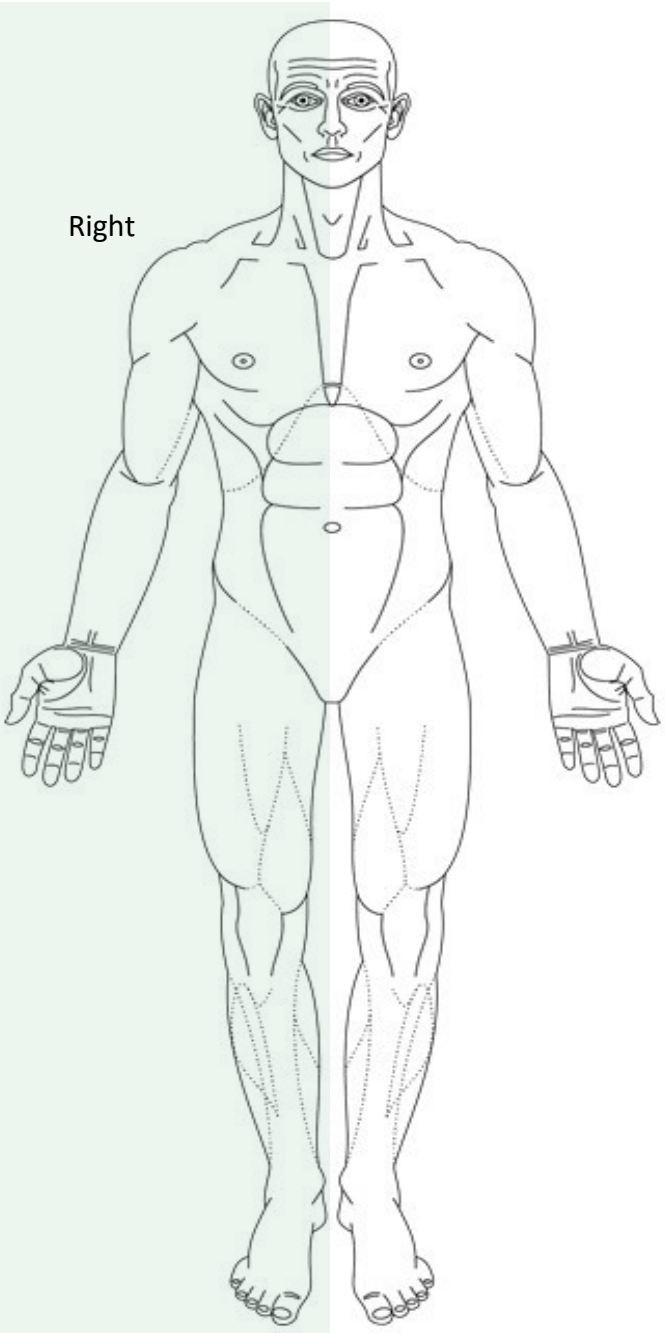
_____

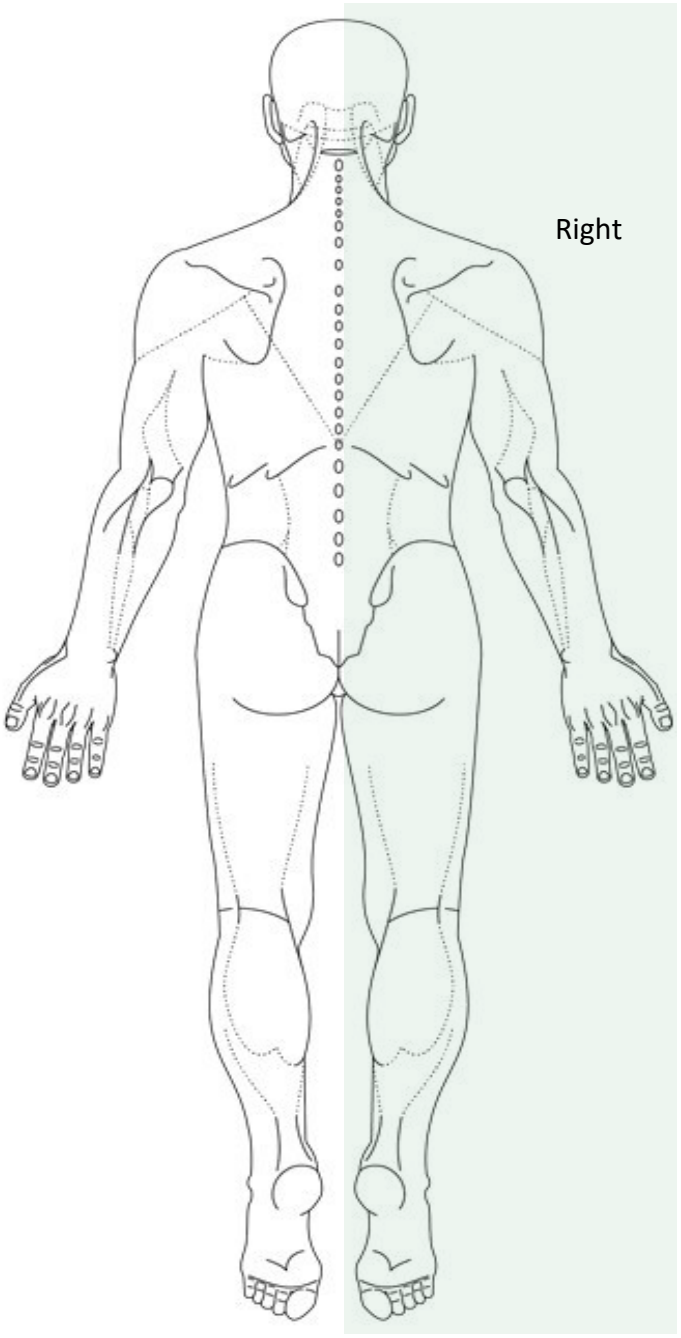
_____

_____

Name: _____ Visit Date _____/ _____/ _____

☐ There have not been any significant changes since my last clinic visit _____/ _____/ _____





Changes since last encounter

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