OGDEN CLINIC

Neurology Follow-Up Appointment Information

Patient Name: _____ DOB: _____

Date of Service: _____ Date of Last Clinic Visit in Neurology: _____

Welcome to Ogden Clinic's Neurology Department. Please take a moment and update your information so that we can work together to make the most of your visit! It's a good idea to think about what you'd like to share before the actual visit and this form can help you organize your thoughts.

1. Overall, since last visit are you doing: **BETTER** **WORSE** **SAME** (circle one).
2. What information or concerns do you want to share with your provider today?
   (Please list from most important to least important):
   1._____
   2._____
   3._____
   4._____
   5._____
3. Have your medications changed since last visit? **YES** **NO** (Circle One). If YES please explain:
   _____
   _____
   _____
4. Please review the list of medication we have on filed for you and make appropriate changes if needed
5. Have you had any significant change in your health since last visit? **YES** **NO** (Circle One). If YES please explain: _____
   _____
   _____
6. Have you had any diagnostic testing (for example Labs, X-Rays, CT's, MRI's) done since last visit? **YES** **NO** (Circle One). If YES, what testing and at what facility? _____
   _____
7. Have you had any medical procedures or been hospitalized since last visit **YES** **NO** (Circle One). If YES, explain nature of procedure/hospitalization and let usknow what facility was used: _____
   _____
   _____

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Are you experiencing any of the following symptoms? Circle Yes or No

Fever/chills	YES	NO	**Weight gain/loss**	YES	NO
Lightheadedness	YES	NO	**Night sweats**	YES	NO
Congestion/runny nose	YES	NO	**Thyroid disease**	YES	NO
Shortness of breath	YES	NO	**Wheezing**	YES	NO
Edema	YES	NO	**Dizziness**	YES	NO
Palpitations	YES	NO	**Ulcers**	YES	NO
Constipation	YES	NO	**Diarrhea**	YES	NO
Easy bruising	YES	NO	**Prolonged bleeding**	YES	NO
Difficulty urinating	YES	NO	**Joint stiffness**	YES	NO
Muscle aches	YES	NO	**Painful joints**	YES	NO
Weakness	YES	NO	**Extremity pain**	YES	NO
Eczema	YES	NO	**Rash**	YES	NO
Insomnia	YES	NO	**New, persistent, or unusual headaches**	YES	NO
Seizures	YES	NO	**Memory loss**	YES	NO
Tics	YES	NO	**Tingling/Numbness**	YES	NO
Anxiety	YES	NO	**Depressed mood**	YES	NO
Difficulty sleeping	YES	NO			