PHYSICIANS' CLINIC
of Iowa, P.C.

NEUROLOGY RECHECK FORM

Date of Birth _____ First Name _____ Last Name _____

Do you have any new problems, issues, or complaints? _____

_____

Please check any symptoms that you have experienced in the last week:

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Recent Weight Increase
- ☐ Recent Weight Loss

Endocrine
- ☐ Excessive Thirst
- ☐ Heat Intolerance
- ☐ Cold Intolerance

Skin
- ☐ Skin Rash
- ☐ Skin Lump

Eyes
- ☐ Blurry Vision
- ☐ Seeing Double

Ear/Nose/Throat
- ☐ Sore Throat
- ☐ Nasal Congestion

Cardiovascular
- ☐ Chest Pain or Discomfort
- ☐ Palpitations
- ☐ Leg Swelling

Respiratory
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Frequent Cough

Hematological
- ☐ Swollen Glands in Neck
- ☐ Easy Bleeding - Recurrent

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn

Musculoskeletal
- ☐ Joint Pain
- ☐ Neck Pain
- ☐ Back Pain

Psychological
- ☐ Depression
- ☐ Anxiety

Genitourinary
- ☐ Urinary Loss of Control
- ☐ Urinary Frequency at Night
- ☐ Painful Urination

Sleep
- ☐ Snoring
- ☐ Daytime sleepiness
- ☐ Stopping breathing during sleep
- ☐ Restless feeling in legs at night
- ☐ Insomnia

TOBACCO, ALCOHOL & DRUG USE:

Do you use tobacco? ☐ Yes ☐ No ☐ Past ☐ Smokeless Tobacco How many packs (average)? _____ per ☐ day ☐ week ☐ month

Do you use alcohol? ☐ Yes ☐ No If yes, how much? _____ Have you used drugs for non-medicinal purposes? ☐ Yes ☐ No

Do you have an advanced directive? ☐ Yes ☐ No If yes, who is your surrogate decision maker? _____