DALLAS NEUROLOGICAL ASSOCIATES

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John Harney, M.D.

Patient Follow-up Form

Patient Name: _____
Date of Birth: _____
Date of Appointment: _____
Reason for Visit: _____
Primary Care Physician _____

Medication	Dose	Frequency	Prescribing Physician
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

Side Effects from Medications	
NONE	☐
NAUSEA	☐
SEDATION	☐
FATIGUE	☐
CONFUSION	☐
CONSTIPATION	☐

Allergies
1.
2.
3
4.
5.
6.

Any New Syptoms? Yes ☐ NO ☐

If So, Please describe: _____

Review of symptoms

Please check off any symptoms that apply on the left side of the page

Patient Assessment		Physician Assessment
1. General Symptoms:		1.
Fatigue	☐	
Fever	☐	
Weight Gain	☐	
Weight Loss	☐	
Change in bowel Movement	☐	
2. Skin:		2.
Rash	☐	
3. Cardiac:	☐	
Chest Pain	☐	3.
Palpitations	☐	
4. Respiratory:		
Shortness of Breath	☐	4.
Cough	☐	
Wheezing	☐	
5. Gastrointestinal:		
Abdominal Pain	☐	5.
Constipation	☐	
Diarrhea	☐	
Bleeding	☐	
6. Urinary:		
Burning	☐	6.
Incontinence	☐	
Inability to urinate	☐	
Change in sexual funct.	☐	
7. Peripheral Vascular:		
Swelling	☐	7.
Coolness	☐	
Leg pain (w/ exercise)	☐	
8. Neurological:		
Headache	☐	8.
New Weakness	☐	
New numbness(tingling)	☐	
Tremor	☐	
Balance Difficulty	☐	
Depression	☐	
Anxiety	☐	

Medication Use:

Is there any concern about misuse of medication? ☐ Yes ☐ No
Is there any concern about? (check all that apply)

- ☐ Tolerance
- ☐ Dependency
- ☐ Toxicity

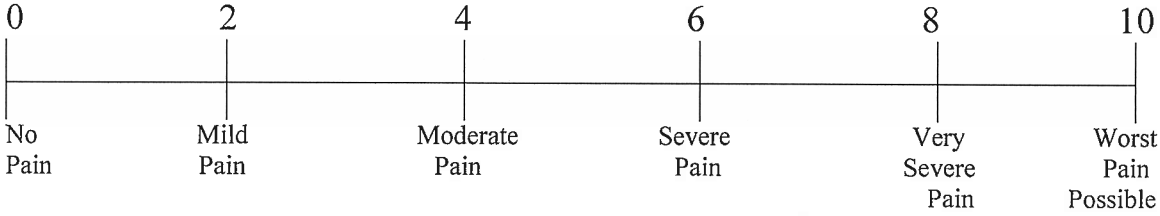
Do you feel that you benefit from the medication? ☐ Yes ☐ No
If so, how are you benefiting? _____

_____

Have you experienced any new pain? ☐ Yes ☐ No
Describe: _____

_____

PAIN SCALE RATING



Current: _____Avg. _____Best _____Worst
Previous: _____Avg. _____Best _____Worst

FUNCTIONALITY

Circle the one number that best describes your overall abilities regarding; work inside, work outside, relations with other people, sleep, enjoyment of life, and walking ability.

0 = Does not interfere 10 = Completely Interferes

Current:

0 1 2 3 4 5 6 7 8 9 10

Previous:

0 1 2 3 4 5 6 7 8 9 10

CAGE/AID

In the last 3 months, have you felt you should cut down on alcohol or drugs? ☐ Yes ☐ No

In the last 3 months, has anyone annoyed you by telling you to stop drinking or using drugs ☐ Yes ☐ No

In the last 3 months, have you felt guilty or bad about drinking or using drug? ☐ Yes ☐ No

In the last 3 months, have you been waking up wanting to use alcohol drugs? ☐ Yes ☐ No