NEUROSCIENCE CENTER℠
Advanced Technology – Complete Care

Please circle all the following that apply:

Constitutional:

Fatigue
Fever
Weakness
Weight Gain
Weight Loss
Tremor

Nose/Mouth/Throat:

Hoarseness
Smell or Taste
Vertigo
Snoring
Other

Neurology:

Dizziness
Headaches
Memory
Numbness, Left or Right side
Sleep/Insomnia/Snoring

Musculoskeletal:

Pain-Left, Right or Bilateral
Spasm- Left, Right or Bilateral
Weakness- Left, Right or Bilateral

Gastroenterology:

Abdominal pain
Anorexia
Constipation
Diarrhea

Endocrine:

Thyroid, High or Low
Diabetes

Vision:

Blurred vision-Light, Right or Both
Other

Hematologic/Lymphatic:

Anemia
Other

Pulmonary:

Anxiety
Depression
Hallucinations

Skin: Breast Lumps-Rash

Worsening:

Have any of your symptoms become worse?

_____ **YES** _____ **NO**

Explain: _____

_____

Any New Problems?

_____ **YES** _____ **NO**

If yes, please specify number of falls

Explain: _____

_____

Hospitalization/Surgeries

Have you been hospitalized or had surgery since your last visit?

Explain: _____

_____

Balance/Motor Skills

In the past year, have you had any falls?

_____ **YES** _____**NO**

If yes, please specify the number of falls.

_____ falls in the past year.