

Date Today: _____ NAME: _____ NRC #: _____

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Follow up visit form: Please note any changes from you initial or last visit

HAS your PCP changes: NO ___ YES ___, Name and address _____

LIST AND DESCRIBE THE NEUROLOGICAL PROBLEMS KNOWN TO THE PHYSICIAN AND CHANGES FROM LAST VISIT.

1. _____
2. _____
3. _____

DESCRIBE ANY NEW SYMPTOMS YOU WANT US TO KNOW ABOUT

1. _____
2. _____

Any new allergy: No Yes: _____

Mark symptoms:

- JOINT PROBLEMS: NONE ___ , YES _____
- EAR NOSE AND THROAT: NONE ___ , YES _____
- VISUAL SYMPTOMS: NONE ___ , YES _____
- RESPIRATORY: NONE ___ , YES _____
- CARDIAC: NONE ___ , YES _____
- SKIN PROBLEMS: NONE ___ , YES _____
- STOMACH OR BOWEL: NONE ___ , YES _____
- URINARY OR KIDNEY : NONE ___ , YES _____
- PSYCHOLOGICAL/PSYCHIAT: NONE ___ , YES _____
- HORMONE/ENDOCRINE: NONE ___ , YES _____

Most recent sigmoidoscopic or proctoscopic examination: _____ Normal ___ Abnormal ___

WOMEN

Abnormal Pap Smear? Yes ___ No ___ Last Pap smear? _____ Last menstrual period? _____

Recent Mammogram? _____ Number of pregnancies? _____ Number of miscarriages? _____

- Any NEW illness identified or surgery since last visit NO YES _____
- Any NEW changes in your family's health history? NO YES _____
- Recent changes in your job, work status, or marital status? NO YES _____

List all prescription and supplemental medications you are currently taking , and underline new medication

Medication	Dosage	Frequency (once, twice, etc)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physician use only HT _____, WT _____, BP _____, PULSE _____

Exam Summary:

Reviewed patients old records : _____ reviewed images (interpreted or read) _____

Labs _____ Biopsy _____ Xrays/MRI _____ EMGS _____

Request for info or tests results from: _____

Diagnosis:

1. _____
2. _____
3. _____
4. _____