

**David Tabby, D.O. | Optimum Neurology
Follow-Up Visit Questionnaire**

Name _____ Date of Birth _____ Today's Date _____

Since your last visit, have you:	If yes, please explain:
Been admitted to a hospital or emergency room?	
Been diagnosed with any new conditions?	
Had x-rays, blood or other tests?	

Since your last visit to our office, have you had any of these problems?

General		Cough	Neurological
Weight change		-	Memory loss
Fevers		Gastrointestinal	Tingling
Chills		Abdominal pain	Numbness
Fatigue		Nausea	Muscle weakness
Poor sleep		Vomiting	Tremor
-		Heartburn	Poor balance
Eyes		Constipation	-
Blurred vision		Diarrhea	Psychiatric
Loss of vision		-	Nervousness
-		Genitourinary	Sadness
Head and neck		Frequent urination	Mood swings
Headache		Painful urination	-
Ear infections		Hesitancy	Endocrine
Sinus infections		-	Excessive thirst
Sore throat		Musculoskeletal	Sensitive to heat
-		Joint pain	Sensitive to cold
Cardiovascular		Neck or back pain	-
Chest pain		Arm or leg pain	Blood
Rapid heartbeat		-	Swollen glands
Black-outs		Skin and hair	Bleeding
-		Skin rash	-
Respiratory		Itching	Immunologic
Shortness of breath		Hair loss	Frequent colds
Wheezing		-	-