WASHINGTON
NEUROLOGY & PHYSICIANS

FOLLOW UP INTAKE FORM

[Please Indicate " SAME " If NO Changes]

Today's Date : / /

Reason for your visit : _____

First Name : _____ **Middle Initial :** _____ **Last Name :** _____

Date of Birth : / /

MEDICATION CHANGES FROM LAST APPOINT :

DRUG NAME	DOSE	FREQUENCY

PLEASE CIRCLE ANY CHANGES SINCE LAST APPOINTMENT AND INDICATED CHANGE IN LINE PROVIDED :

PRIMARY CARE PHYSICIAN / PREFERRED PHARMACY / ALLERGIES / WORK OR LIVING SITUATION / SMOKING / ALCOHOL / RECREATIONAL DRUG USAGE

_____

_____

PLEASE CIRCLE ANY CHANGES IN CURRENT SYMPTOMS LISTED BELOW OR CIRCLE
DO YOU HAVE ANY OF THESE SYMPTONS ? [CIRCLE ANSWER]

Systems	Symptoms
Constitutional	Chills / Night Sweat / Fatique / Fever / Sleep Disturbances / Weight Gain / Weight Loss
Eye	Blurred Vision / Double Vision / Pain / Redness / Vision Changes / Dry Eyes
Ear, Nose, Throat	Earache / Ear Discharge / Hearing Loss / Tinnitus / Nose Bleed / Sinus Problem / Sore Throat / Hoarseness
Cardiovascular	Chest Pain / Chest Tightness / Lower Extremity Edema / Palpitation / Hypertension / Lightheadedness / Passing Out
Respiratory	Cough / Dyspnea at Rest / Pain with Breathing / Shortness of Breath / Wheezing
Gastrointestinal	Abdominal Pain / Constipation / Diarrhea / Heartburn / Incontinence / Nausea / Vomiting / Swallowing Difficulty
Genitourinary	Dysmenorrhea / Erectile / Genital Sores / Incontience / Penile Discharge / Testicular Mass / Urinary Urgency / Urination Pain / Vaginal Discharge
Musculoskeletal	Back Pain / Joint Pain / Joint Redness / Joint Swelling / Muscular Cramps / Muscular Pain / Neck Pain / Sprain
Skin	Lesion / Mass / Mole change / Rash
Neurological	Dizziness / Fainting / Headache / Memory Loss / Numbness / Seizure / Stroke / Tremor / Unstable Gait / Vertigo / Weakness
Psychiatric	Anxiety / Depression / Hallucinations / Mania / Substance Abuse / Suicide Attempts
Endocrine	Cold Intolerance / Heat Intolerance / Polyuria / Diabetes / Thyroid Problem
Heme / Lymph	Blood Clots / Cold Extremities / Hx of Bleeding Problem / Swelling / Tenderness
Allegic / Immuno	Allergic Reactions / Hives / Itching / Sinus Pressure / Immune Deficiencies

OTHERS :

Patient Signature: _____ **Print Name:** _____ **Date:** _____

421 S 47TH AVE YAKIMA WA 98908 / TEL : 509.969.9393 / FAX : 509.202.4603