Maine Medical
PARTNERS
Neurology

Adult Return Visit Questionnaire

Name of Patient: _____ **Date of Birth:** ____/____/_____

Primary Care Physician: Dr._____ **Today's Date:** ____/____/_____

Specific questions you would like addressed at this return visit: _____

Current Medications & Dose:

☐ **See Attached List**

☐ **Please Photocopy My List**

Name of Medication (Prescription AND Over-the-Counter)	Dose/ Strength	Number of Tablets			
		Morning	Noon	Afternoon	Bedtime

New Medical Problems (since last visit):

☐ **No Change**

Drug Allergies:

Social History Update:

☐ **No Change**

Marital Status: Married____ Single____ Divorced____ Separated____ Widowed____ Life Partnership____

Smoke? Yes_____ No_____ If yes, how much? _____/day _____/week

Alcoholic Beverages? Yes_____ No_____ If yes, how much? _____/day _____/week

Occupation: _____

****Please turn this form over and complete the back.****

Reviewed by: _____

Name: _____ Date: _____

Have you had any of the following symptoms recently?

	Yes	No	
Neurologic			
			Headache
			Memory Loss
			Fainting/Spells
			Tremor
			Weakness
			Numbness
			Balance Problems
			Vertigo/Dizziness
Psychological			
			Insomnia
			Depression
			Anxiety
			Crying Spells
Eyes			
			Blurred Vision
			Double Vision
			Eye Pain
Ear, Nose & Throat			
			Hearing Loss
			Ear Pain
			Difficulty Swallowing
Musculoskeletal			
			Neck Pain
			Arm Pain
			Back Pain
			Leg Pain
			Joint Pain
Cardiovascular			
			Chest Pain
			Irregular Heartbeat
			Rapid Heartbeat
Genitourinary			
			Bladder Control Problems
			Sexual Problems
			Recent Urinary Infections
Gastrointestinal			
			Diarrhea
			Constipation
			Nausea
			Vomiting
Respiratory			
			Shortness of Breath
			Coughing
Constitutional			
			Recent Fever
			Weight Loss
			Weight Gain

Reviewed by: _____