HEADACHE CENTER at Piercey Neurology LLC

FOLLOW UP QUESTIONNAIRE

VISIT DATE: ___________________________

NAME: ____ **DOB:** _____________________

Since last visit, my headaches are (CIRCLE ONE): THE SAME BETTER WORSE

New symptoms or concerns related to your headaches: NONE

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Questions (*related to your headaches*) to be addressed at your visit today: NONE

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REVIEW OF SYSTEMS

Please indicate if you have experienced any of these symptoms in the past 2 MONTHS:

□ fatigue	□ chest pain	□ tingling
□ fevers	□ palpitations	□ seizures
□ sweats	□ hand/feet swelling	□ passing out
□ weight loss	□ cough	□ tremor
□ weight gain	□ difficulty breathing	□ vertigo
□ insomnia	□ diarrhea	□ depression
□ poor sleep	□ constipation	□ anxiety
□ blurred vision	□ abdominal pain	□ memory difficulties
□ double vision	□ joint pain	□ cold intolerance
□ vision loss	□ arthritis	□ heat intolerance
□ tinnitus	□ back pain	□ abnormal bruising
□ decreased hearing	□ skin rash	□ easy bleeding
□ difficulty swallowing	□ muscle weakness	□ seasonal allergies

WT: ________ **lbs** **BP:** ______ **/**______ **P:** ________ **RR / IR**