NEUROLOGY ASSOCIATES, P.A.

NA#_____

Follow-up Medical Questionnaire

Patient Name_____ **Date**_____

1. Are you seeing a new doctor since your last visit? If so, who is it?_____
2. Since your last visit are you better, worse, or the same?_____
3. Do you have a new problem that was not discussed at your last visit? If so what is it?
   _____
   _____
4. Have you been hospitalized since your last visit? _____
5. If your medications have changed, list changes.
   _____
   _____
   _____
6. Are there any questions you want your provider to answer at this visit?_____If so, list below.
   _____
   _____
7. **For females only**: Date of last menstrual period_____ Are you pregnant?_____

Sleep Patterns (Please complete at each visit)**:**

How likely are you to doze off or fall asleep (not just feel tired) in the following situations?

Situation	Never=0	Slight chance=1	Moderate chance=2	High Chance=3
Sitting & reading				
Watching TV				
Sitting inactive in a public place like a theater or meeting				
Riding as a passenger in a car for an hour without a break				
Lying down to rest in the afternoon				
Sitting and talking to someone				
Sitting quietly after lunch without alcohol				
In a car while stopped for a few minutes				
Column Total				

Add Column Totals for Total Score_____

1. Average amount of sleep you get most nights_____
2. Check one: After a full night of sleep, you feel ☐Rested and refreshed or ☐Excessively tired throughout the day.
3. Do you kick your feet or legs throughout the night?_____
4. Do you suffer from morning headaches?_____
5. Do you snore loudly?_____
6. Do you stop breathing in your sleep?_____

(Continue on Other Side)

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Insomnia Scale If you have sleep difficulty/insomnia, finish this section:

1. How many nights a week do you have problems falling asleep or staying asleep? _____
2. How long have you had this problem? _____
3. Rate the severity of the following problems in the chart below:

	No Problems=0	Mild Problem=1	Moderate Problem=2	Severe Problem=3
Problems falling asleep				
Difficulty staying asleep/frequent awakenings				
Awakening earlier than you wish				
Daytime sleepiness				
Poor/impaired function at home or work				
Mood swings				
Memory loss				
Being hyperactive,anxious, or nervous during the day				
Column Total				

Add Column Totals for Total Score _____

For Headache Patients Only:

1. Are you having any side-effects from your headache medication?_____

   If yes, please describe_____
2. How often are your headaches occurring now? _____
3. When was your last headache? _____
4. How severe was it (10 is the worst pain)? 0 1 2 3 4 5 6 7 8 9 10
5. Did you take any medication to try to stop the headache?_____
6. What did you take?_____
7. Did the medication help?_____
8. Did you have any bad side effects from the medicine?_____

   If yes, describe: _____

Patient Signature_____