JERRY V. MARLIN, M.D. NEUROLOGICAL SURGERY
FOLLOW UP OFFICE VISIT QUESTIONNAIRE

Name: _____ Date: ____ / ____ /_____

Address: _____

Home phone #: _____ Work phone #: _____

Health Insurance: _____

Have you had any new surgical procedures since your last office visit? Yes _____ No _____

LIST: _____

Did you develop any new medical illnesses since your last office visit? Yes _____ No _____

LIST: _____

Do you smoke? Yes ____ No ____ How much? _____

Please list your current medications, dose and time taken.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

Please list all allergies to medications or to foods. _____

_____

Who is your Primary Care Physician? _____

Name:_____ **Date:** _____

MEDICAL HISTORY

Do you have indigestion currently? Yes ___ No ___ Weight loss? Yes___ No___

Do you have any problems with nausea or vomiting currently? Yes ____ No ___

Have you recently notice any blood in your stool or urine? Yes_____ No____When?_____

Do you have any bleeding Tendency Yes____ No ___ Or Nose bleeds Yes____ No___

Do you have any bleeding when you brush your teeth? Yes ___ No___

Are you shortness of breath? Yes____No____ or Coughing? Yes___ No__

Are you having problems with chest pain recently or in the past? Yes____No____

Do you have problems with your vision Yes ____ No _____

or double vision or blurred vision? Yes____ No____

Do you have problems with your vision such need for reading glasses? Yes____ No____

Have you had any recent infections? Yes____ No ____ or Fever? Yes____ No____

Have you had problems with swallowing? Yes____ No _____

Sore throat? Yes____ No ____ Or Earaches? Yes____ No _____

Do you have headaches? Yes____ No____ How often do you have headaches?_____

Do you have problems with your hearing? Yes ____ No _____

Do you have problems with dizziness? Yes ____ No___

Do you have any metal in your body? Yes____ No____ or implanted devices(such as a pacemaker) Yes____ No____

Do you have dentures? Yes ____ No _____

Do you have any problems with depression? Yes___ No___

or Memory loss Yes____ No____

Do you have a history of sleep apnea? Yes_____ No _____ Do you snore at night? Yes ____ No _____

Do you have a history of stopping breathing at night? Yes_____ No ____

Do you use a CPAP or breathing machine at night? Yes ___ No ____

Name:_____ Date: _____

PAST MEDICAL HISTORY:

Please list any Medical Illness or Medical diagnosis or Health Care problem:

1._____

2._____

3._____

4._____

5._____

6. _____

Are you Pregnant: Not/Applicable____ Yes___ No___

Have you been diagnosed with or have you had any of the following conditions?

High blood pressure Yes ___ No ___ Diabetes Yes ___ No ___

Liver Disease or Hepatitis Yes ___ No___ Renal Disease: Yes ___ No__

Heart Disorders such as a heart attack or cardiac arrhythmia? Yes ___ No ___

Stroke: Yes ___ No___ Seizure: Yes ___ No ___

Urinary Tract Infections Yes ___ No___ Stomach Ulcers :Yes ___ No ___

Lung Disorders: Yes ____ No____ Asthma or wheezing: Yes ___No __
Arthritis : Yes ___ No ___

Thyroid Disorder: Yes___ No___ History of Tuberculosis Yes____ No___

History of positive test for HIV or History of AIDS: Yes___ No____