



BOOTH GARDNER PARKINSON'S CARE CENTER

RETURNING PATIENT FORM (for patients of Dr. Agarwal and Dr. Griffith)

DATE:	NAME:	AGE:
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Please bring this completed form to your next visit or arrive at least **30 minutes** before your scheduled appointment to complete.

Please describe the *three* most important problems you would like to discuss today.

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When was the last time you saw your regular doctor (primary care physician) for an exam? \_\_\_\_\_

**Please check all the conditions you are experiencing now:**

<input type="checkbox"/> Pain: where?		
<input type="checkbox"/> Muscle cramps	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Nausea/vomiting
<input type="checkbox"/> Tremor	<input type="checkbox"/> Cough	<input type="checkbox"/> Sexual dysfunction
<input type="checkbox"/> Involuntary movements	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Bladder problems
<input type="checkbox"/> Freezing	<input type="checkbox"/> Confusion	<input type="checkbox"/> Headache
<input type="checkbox"/> Stiffness	<input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Change in vision
<input type="checkbox"/> Slowness of movement	<input type="checkbox"/> Visual or Auditory hallucinations	<input type="checkbox"/> Loss of hearing
<input type="checkbox"/> Weakness	<input type="checkbox"/> Vivid dreams	<input type="checkbox"/> Change in smell
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Depressed, sad mood	<input type="checkbox"/> Leg swelling
<input type="checkbox"/> Change in handwriting	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Heart palpitations
<input type="checkbox"/> Balance problems	<input type="checkbox"/> Obsessions	<input type="checkbox"/> Infection
<input type="checkbox"/> Falls	<input type="checkbox"/> Gambling	<input type="checkbox"/> Chills/sweats
<input type="checkbox"/> Lightheadedness/ Fainting	<input type="checkbox"/> Hypersexuality	<input type="checkbox"/> Fever
<input type="checkbox"/> Changes in swallowing	<input type="checkbox"/> Daytime sleepiness	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Soft speech	<input type="checkbox"/> Change in sleep pattern	<input type="checkbox"/> Rash
<input type="checkbox"/> Drooling	<input type="checkbox"/> Weight gain/loss	<input type="checkbox"/> Bruising
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Change in appetite	<input type="checkbox"/> Bleeding
	<input type="checkbox"/> Constipation	<input type="checkbox"/> Sinus problem

What medications need a prescription refill: Drug name, 30 days or 90 days

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**Please check all the conditions you are experiencing now:**

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|---|--|---|
| <input type="checkbox"/> Pain: where? _____           | <input type="checkbox"/> Pneumonia                         | <input type="checkbox"/> Sexual dysfunction |
| <input type="checkbox"/> Muscle cramps                | <input type="checkbox"/> Cough                             | <input type="checkbox"/> Bladder problems   |
| <input type="checkbox"/> Tremor                       | <input type="checkbox"/> Memory loss                       | <input type="checkbox"/> Headache           |
| <input type="checkbox"/> Involuntary movements        | <input type="checkbox"/> Confusion                         | <input type="checkbox"/> Change in vision   |
| <input type="checkbox"/> Freezing                     | <input type="checkbox"/> Difficulty concentrating          | <input type="checkbox"/> Loss of hearing    |
| <input type="checkbox"/> Stiffness                    | <input type="checkbox"/> Visual or Auditory hallucinations | <input type="checkbox"/> Change in smell    |
| <input type="checkbox"/> Slowness of movement         | <input type="checkbox"/> Vivid dreams                      | <input type="checkbox"/> Leg swelling       |
| <input type="checkbox"/> Weakness                     | <input type="checkbox"/> Depressed, sad mood               | <input type="checkbox"/> Heart palpitations |
| <input type="checkbox"/> Fatigue                      | <input type="checkbox"/> Anxiety                           | <input type="checkbox"/> Infection          |
| <input type="checkbox"/> Change in handwriting        | <input type="checkbox"/> Obsessions                        | <input type="checkbox"/> Chills/sweats      |
| <input type="checkbox"/> Balance problems             | <input type="checkbox"/> Gambling                          | <input type="checkbox"/> Fever              |
| <input type="checkbox"/> Falls                        | <input type="checkbox"/> Hypersexuality                    | <input type="checkbox"/> Sore throat        |
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| <input type="checkbox"/> Changes in swallowing        | <input type="checkbox"/> Change in sleep pattern           | <input type="checkbox"/> Bruising           |
| <input type="checkbox"/> Soft speech                  | <input type="checkbox"/> Weight gain/loss                  | <input type="checkbox"/> Bleeding           |
| <input type="checkbox"/> Drooling                     | <input type="checkbox"/> Change in appetite                | <input type="checkbox"/> Sinus problem      |
| <input type="checkbox"/> Shortness of breath          | <input type="checkbox"/> Constipation                      |   |
|   | <input type="checkbox"/> Nausea/vomiting                   |   |

What medications need a prescription refill: Drug name, 30 days or 90 days

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