**Neurosurgery Associates, LLC**
**Joseph A. Shehadi, MD, FRCSC, FACS**
**Tiffany Epps, CNP**
**FOLLOW UP OFFICE VISIT QUESTIONNAIRE**
(Please Print)

Name _____ Age _____

Today's Date_____ Current Phone#_____

□ Right Hand □ Left Hand Height_____ Weight _____

Pharmacy Preference (include location) _____

Primary Care Physician _____

**Chief Complaint (CC :)** _____

1. Have your symptoms changed in the last 30 days? □ **Better** □ **Worse** □ **Same**

2. List Any New Treatment(s) since your last visit: _____ _____

Physical Therapy □ Y □ N Helping? □ Y □ N Date completed _____

Bracing □ Y □ N Helping? □ Y □ N

Injections □ Y N □ Helping? □ Y □ N Dates _____

3. Any New Imaging, such as CT, MRI or X-rays? □ Y □ N

If so What and When? _____

4. Rate your pain on average *(0 is no pain, 10 is worst possible pain)*: 0 1 2 3 4 5 6 7 8 9 10

Pain at worst 0-10 _____ Pain at best 0-10 _____

5. What makes the pain better? _____

6. What makes the pain worse? _____

7. **Circle** the words that best describe your **pain**: Intermittent Constant

8. Do you have numbness? □ Y □ N Where? _____ Burning? □ Y □ N Where? _____

9. Urine incontinence? □ Y □ N Bowel incontinence? □ Y □ N Sexual Dysfunction? □ Y □ N

11. Are you on **any NEW** medications or have you **stopped** any medications since last seen here? □ Y □ N

| **Medication (including over the counter)** | **Dosage** | **How often Taken** |
|---|---|---|
| | | |
| | | |

12. Have you developed any **NEW** medication ***Allergies?*** □ **Y** □ **N** Which ones_____

**Review of Symptoms:**

13. Have you had any of the following in the past 30 days? *(mark all that apply)*

| | | |
|---|---|---|
| ❑ Fever | ❑ Fainting | ❑ Arm or leg weakness |
| ❑ Unintentional weight loss | ❑ Dizziness/lightheadedness | ❑ Arm or leg pain |
| ❑ Excessive fatigue | ❑ Seizures | ❑ Neck pain |
| ❑ Night sweats | ❑ Headaches | ❑ Back pain |
| ❑ Loss of appetite | ❑ Problems with your memory | ❑ Joint swelling |
| ❑ Insomnia | ❑ Disorientation | ❑ Joint stiffness |
| ❑ Double or blurred vision | ❑ Difficulty with speech | ❑ Joint pain |
| ❑ Face weakness | ❑ Inability to concentrate | ❑ Muscle cramps/spasms |

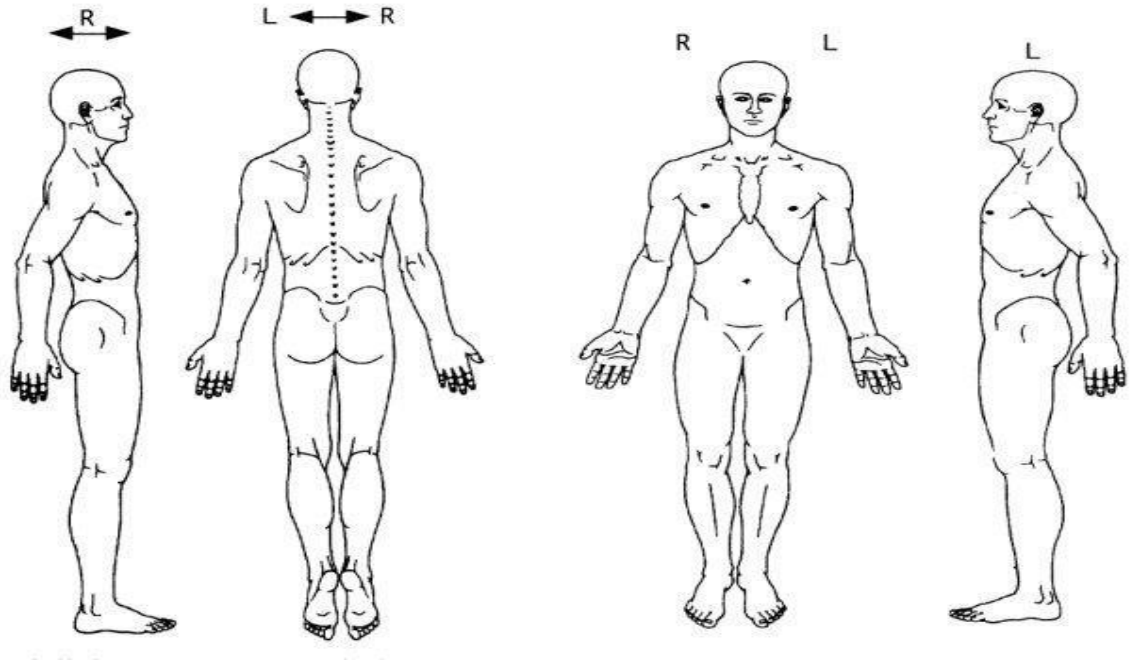
14. Please list changes to your medical/surgical or social history: _____

Are you a current smoker: _____Do you currently consume alcohol_____

15. Have you visited our **website DrShehadi.com** since your last visit? □ Y □ N

Have you seen our Patient Resources Section? □ Y □ N

16. Please **SHADE** in area(s) where your **PAIN is located and X where the NUMBNESS** is located:




****Patient Signature**_____ **Date**_____

Printed Name _____