

Neurology Center of Fairfax

Information for Our Patients

Thank you for choosing us to provide your neurological care. Our goal is to provide you with top quality care. Please help us by providing your most up to date medical information at each visit.

For each visit you **MUST**:

- Fill out all information forms (both sides) before you see your doctor. Your doctor needs current information to provide you with the best care. List your questions and concerns so they can be addressed during your visit. Multiple concerns or symptoms may require further visits.
- Complete the specific disease information sheets (i.e., Multiple Sclerosis, Parkinson's disease and Sleep) if appropriate.
- Provide a complete and up-to-date written medication list with doses and times medications are taken. Include all over-the-counter medications, vitamins and supplements.
- Get prescriptions and refills for all of your medications at the time of your visit. If you do not, you may need to return for a refill visit with our nurses. There is a charge for emergency prescription refills between visits.
- We cannot accept prescription requests from pharmacies for you due to potential medication errors. You must obtain prescriptions and refills at the time of your visit. Your prescriptions are your responsibility to be sure you receive the correct medication and the correct dose.
- To save time at your next visit, please take forms home and fill them out ahead of time. You can also download the forms from our website www.neurologycenteroffairfax.com.
- Your co-payment and your co-insurance are due at the time of service. If you do not pay these at the time of your visit, there is a \$10 administrative fee and an additional \$10 service charge for each bill we send. These charges are not covered by health insurance. We accept VISA, MasterCard, Discover, cash and checks.
- Please be respectful of other patients and arrive on time for your appointments. Please call us if you are delayed by traffic at 703-876-0800. If you are 15 minutes late or more, we may not be able to see you the same day. We understand the problems with traffic in Northern Virginia, but we cannot inconvenience patients who do arrive on time for their appointments.
- Our office does not communicate with patients via email.

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THIS FORM MUST BE COMPLETED AND BROUGHT TO EACH FOLLOW-UP VISIT

NAME: _____ DATE: _____

1. A FULL LIST OF ALL CURRENT MEDICATIONS INCLUDING VITAMINS AND OTHER OVER-THE-COUNTER MEDICATIONS OR SUPPLEMENTS MUST BE PROVIDED AT EACH VISIT.

YOU MAY USE OUR MEDICATION LIST (KEEP A COPY FOR YOUR RECORDS)

OR YOU MAY ATTACH A COPY OF YOUR MEDICATION LIST (HAVE US MAKE A COPY).

2. LIST ANY SIGNIFICANT MEDICAL EVENTS/TESTS DONE SINCE YOUR LAST VISIT, WITH DATES:

3. OTHER MEDICAL PROBLEMS:

STATUS/TREATMENT:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

4. LIST THE THREE (3) MOST IMPORTANT QUESTIONS YOU WANT ANSWERED TODAY:

- 1. _____
- 2. _____
- 3. _____

5. LIST ALL MEDICATIONS YOU NEED REFILLED AND ANY FORMS YOU NEED COMPLETED:

**GET ALL YOUR PRESCRIPTION REFILLS TODAY.
THERE IS A CHARGE FOR ALL PRESCRIPTION REFILLS BETWEEN OFFICE VISITS.**

Tremor/Parkinson's Clinical Symptoms Checklist Form
(Complete Both Sides Prior to Scheduled appointment Time)

Patient Name _____ Date _____

Date of Birth _____

Current Tremor/Parkinson's Medications:

Name of Medication	Strength	Time of dose and # of tablets
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Side Effects (Yes/No) _____

Does your medication last from one dose to the next? (Yes/No)

Compulsive behaviors: (i.e. excessive spending, gambling, or hypersexual behaviors)? (Yes/No) _____

History of: Glaucoma (Yes/No)
 Melanoma (Yes/No)

Other Medical Problems:

1. _____
2. _____
3. _____
4. _____
5. _____

Additional Medications

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

CONTINUE ON REVERSE SIDE

Motor Symptoms

Tremor (Yes/No)	mild	moderate	severe
Rigidity (Yes/No)	mild	moderate	severe
Slowness (Yes/No)	mild	moderate	severe
Dyskinesia/Involuntary Movement (Yes/No)	mild	moderate	severe
Abnormal Hand/Foot Posturing (Yes/No)	mild	moderate	severe

Walking

Shuffling (Yes/No)	mild	moderate	severe
Start Hesitation (Yes/No)	mild	moderate	severe
Freezing (Yes/No)	mild	moderate	severe
Imbalance (Yes/No)	mild	moderate	severe
Use of assistive devices	(Yes/No) _____		
Any falls	(Yes/No) _____		

Activities of Daily Living/Dressing and Showering:

(Independent/Needs help) _____
Difficulty with Swallowing, Eating, or Drooling (Yes/No) _____

Associated Symptoms

Constipation/Diarrhea	(Yes/No) _____
Urinary Symptoms	(Yes/No) _____
Sexual Dysfunction	(Yes/No) _____
Lightheadedness (orthostasis)	(Yes/No) _____
Double Vision	(Yes/No) _____
Depression	(Yes/No) _____
Anxiety	(Yes/No) _____
Sleep Disturbances	(Yes/No) _____
Hallucinations	(Yes/No) _____
Confusion	(Yes/No) _____
Memory Loss	(Yes/No) _____
Speech Difficulty	(Yes/No) _____
Slowness in Processing Information	(Yes/No) _____

Other symptoms? _____

