NYU Langone MEDICAL CENTER

NYU Parkinson's and Movement Disorders Center

Follow Up Patient Questionnaire

Name: _____ **Date:** _____

Accompanied by: _____ **Do you smoke?** CURRENT PAST NEVER

Which neurological symptom bothers you most right now? _____

Any new medical problems, hospitalizations, surgeries, or allergies (since your last visit)? Y N

If yes, then please explain: _____

Medications, Vitamins, & Supplements (or attach your own list):

Medication Name	Dose (or # of mg)	Time:	Time:	Time:	Time:	Time:	Time: