MEDICATION
PATIENT FOLLOW UP FORM

Date: _____ Name: _____

NAME	STRENGTH	FREQUENCY			
1. ANTIBIOTICS:					
			Herxheimers	Yes	No
_____	_____	_____	Effective	Yes	No
			Herxheimers	Yes	No
_____	_____	_____	Effective	Yes	No
2. PAIN MEDS:					
_____	_____	_____			
_____	_____	_____			
3. ANTI INFLAMMATORY:					
_____	_____	_____			
_____	_____	_____			
_____	_____	_____			
4. ANTI DEPRESSANT:					
_____	_____	_____			
_____	_____	_____			
_____	_____	_____			
_____	_____	_____			
5. ANTI SEIZURE					
_____	_____	_____			
_____	_____	_____			
6. OTHER MEDICATIONS:					
_____	_____	_____			
_____	_____	_____			
_____	_____	_____			
_____	_____	_____			
_____	_____	_____			
_____	_____	_____			

LYME PATIENT FOLLOW UP FORM

Date: _____ Name: _____

Please circle on a scale of 0 through 4.
0 being not present and 4 meaning severe symptoms:

	None	Minimal	Mild	Moderate	Severe
1. Chills or mild fever ……	0	1	2	3	4
2. Sore Throat ……	0	1	2	3	4
3. Lymph node pain ……..	0	1	2	3	4
4. Muscle weakness ……	0	1	2	3	4
5. Muscle pain……..	0	1	2	3	4
6. Headaches ……	0	1	2	3	4
7. Joint pain ……	0	1	2	3	4

Specify which joints: _____

_____

Does joint pain move around? Yes ☐ No ☐

8. Neurological symptoms

Light bothers eyes ……	0	1	2	3	4
Forgetfulness ……..	0	1	2	3	4
Irritability ……..	0	1	2	3	4
Confusion; difficulty thinking……..	0	1	2	3	4
Depression ……	0	1	2	3	4
Inability to concentrate ……..	0	1	2	3	4
Brief periods of visual spots or loss of vision..	0	1	2	3	4

9. Sleep disturbance ……	0	1	2	3	4

Too Much ☐ Too Little ☐

10. Fatigue ……..	0	1	2	3	4

Since my last visit I feel: Same ☐ Better ☐ Worse ☐

Patient Comfort Assessment Guide

Name: _____ Date: _____

1. Where is your pain? _____

2. Circle the words that describe your pain.

aching	sharp	penetrating
throbbing	tender	nagging
shooting	burning	numb
stabbing	exhausting	miserable
gnawing	tiring	unbearable

Circle One Occasional Continuous

What time of day is your pain the worst? Circle one.

Morning afternoon evening nighttime

3. Rate your pain by circling the number that best describes your pain at its worst in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

4. Rate your pain by circling the number that best describes your pain at its least in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

5. Rate your pain by circling the number that best describes your pain at its average in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

6. Rate your pain by circling the number that best describes your pain right now.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

7. What makes your pain better? _____

8. What makes your pain worse? _____

9. What treatments or medicines are you receiving for your pain? Circle the number to describe the amount of relief the treatment or medicine provide(s) you.

a) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

b) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

c) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

d) _____ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

10. What side effects or symptoms are you having? Circle the number that best describes your experience during the past week.

a. Nausea	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
b. Vomiting	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
c. Constipation	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
d. Lack of Appetite	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
e. Tired	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
f. Itching	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
g. Nightmares	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
h. Sweating	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
i. Difficulty Thinking	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
j. Insomnia	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine

11. Circle the one number that describes how during the past week <u>pain has interfered</u> with your:

a. General Activity	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
b. Mood	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
c. Normal Work	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
d. Sleep	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
e. Enjoyment of Life	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
f. Ability to Concentrate	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
g. Relations with Other People	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes

Purdue: committed to managed care
Prepared by Elizabeth J. Narcessian, M.D., Clinical Chief of Pain Management, Kessler Institute for Rehanilitation, Inc
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HAMID MOAYAD, D.O., P.A.
NEUROLOGY
AMERICAN ACADEMY OF NEUROLOGY
AMERICAN COLLEGE OF NEUROPSYCHIATRY
AMERICAN SOCIETY OF NEUROIMAGING

CONFIDENTIAL
PATIENT AGENDA

Dear Patient:

To help you make best use of your time with Dr. Moayad, please list the questions you would like to discuss during your appointment.

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

5. _____

_____

_____
Signature

_____
Date