Parkinson's Foundation

PLEASE FILL OUT THE FOLLOWING FORM TO PREPARE FOR YOUR VISIT TODAY. Todays

Date : _____ Date of Birth : _____ Print

Name : _____

Please name the top three items you want to address with your physician at your appointment:

1. : _____
2. : _____
3. : _____

Please list any new medications:

_____

_____

_____

_____

Since your last visit, have you had worsening balance? ☐ YES ☐ NO

Have you fallen? ☐ YES ☐ NO

If you have fallen, how many times have you fallen in the last month? : _____

In the past week, how often have you felt like were about to fall but were able to catch yourself ?

_____

_____

Do you have difficulty using your hands? ☐ YES ☐ NO

If yes, what do you struggle with? (For example, is it difficult to write? Button a shirt? Use a zipper? Use utensils?) :

_____

_____

_____

Do you have tremors? ☐ YES ☐ NO

If yes, what do tremors interfere with in your day-to-day life? :

_____

_____

_____

Are you able to dress yourself, shower, and do your own self-hygiene? ☐ YES ☐ NO

Any changes in your memory since your last visit? ☐ YES ☐ NO

Any hallucinations? (Seeing things that are not actually there?) ☐ YES ☐ NO

In the past two weeks, have you felt down or sad? ☐ YES ☐ NO

In the past two weeks, have you felt more anxious? ☐ YES ☐ NO

Do you feel like you have to urinate too often? ☐ YES ☐ NO

Do you feel a sudden urge to urinate and have to run to the restroom? ☐ YES ☐ NO

Do you ever have accidents such as leakage of urine in your underwear or incontinence? ☐ YES ☐ NO

How often do you have bowel movements? _____

Do you get lightheaded if you stand too quickly? ☐ YES ☐ NO

Do you ever feel like the room is spinning around you? ☐ YES ☐ NO

Do you have any trouble swallowing? ☐ YES ☐ NO

Do you have difficulty falling asleep at night? ☐ YES ☐ NO

Do you have difficulty staying asleep at night? ☐ YES ☐ NO

If you have difficulty sleeping, what wakes you up? _____

Do you have constipation? ☐ YES ☐ NO

Do you have changes in your sense of smell or taste? ☐ YES ☐ NO

If yes, please describe:_____