NEUROLOGY CENTER OF FAIRFAX, LTD.
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Parkinson's Form

Name: _____ D.O.B.: _____ Date: _____

Name of medication	Strength	Time of dose # of tablets	Any side effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Compulsive behavoirs	No	Details: _____
History of glaucoma	No	Details: _____
History of melanoma	No	Details: _____

Motor symptoms in last 6 months

Tremor	None	
Rigidity	None	
Slowness	None	
Dyskinesia/Involuntary Movement	None	
Abnormal hand/foot/truncal posturing	None	

Walking symptoms in last 6 months

Shuffling	None	
Start hesitation	None	
Freezing	None	
Imbalance	None	
Assistive devices	No	Type of Device: _____
Falls	No	Fall Details: _____

Activities of daily living/dressing and showering

Needs help with activities of daily living?	No	Details: _____
Difficulty with swallowing, eating, or drinking	No	Details: _____

Associated symptoms

Constipation/diarrhea	No	Details: _____
Urinary	No	Details: _____
Sexual Dysfunction	No	Details: _____

Name: _____ D.O.B.: _____

Orthostasis	No	Details: _____
Double vision	No	Details: _____
Depression	No	Details: _____
Anxiety	No	Details: _____
Sleep disturbance	No	Details: _____
Hallucinations	No	Details: _____
Confusion	No	Details: _____
Memory loss	No	Details: _____
Speech difficulty	No	Details: _____
Slowness processing information	No	Details: _____
Other symptoms	No	Details: _____