

**SUPPLEMENT to “My Weekly Symptoms Report” for M.D. re-evaluation**  
(This form DOES need to be filled out prior to your re-evaluation appointment with Ayse L. Lee-Robinson, M.D.)

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/2009

**1. (ROS) Review of Systems:**

Circle Y for yes, N for no. If yes, explain;

- Have you had significant weight gain or loss recently? Y / N \_\_\_\_\_
- Are you experiencing headaches or earaches? Y / N \_\_\_\_\_
- Have you been experiencing shortness of breath or chest pain? Y / N \_\_\_\_\_
- Are you noticing dizziness or irregular heart beats? Y / N \_\_\_\_\_
- Have you had diarrhea, constipation or any changes in the color of your stool? Y / N \_\_\_\_\_
- Are you experiencing difficulty urinating or controlling your bladder? Y / N \_\_\_\_\_
- Do you have difficulty with your balance? Y / N \_\_\_\_\_
- Are you using a cane, walker or crutches to walk? Y / N \_\_\_\_\_
- Do you have any skin disorders or skin sores? Y / N \_\_\_\_\_
- Are you noticing increasing weakness or numbness? Y / N \_\_\_\_\_
- Do you have increased joint pains or changes in the motion of your joints? Y / N \_\_\_\_\_
- Do you think you may be depressed? Y / N \_\_\_\_\_

**2. Please describe your work status: Circle - Retired / not working outside of home / Disabled -Unable to work**

a. If **working**, how many **hours** are you working **each week**? \_\_\_\_\_ **List any physical limits you presently have at work (hours & activity)?** \_\_\_\_\_

b. **Do you need any notes for work? Explain what you need** \_\_\_\_\_

**3. List all scheduled and as needed medications that you are taking for your neck / arm / hand &/or back / leg / foot symptoms. Include all pills &/or patches, the dose (or number) taken and the frequency taken daily or weekly.**

|  |  |
|--|--|
|  |  |
|  |  |
|  |  |
|  |  |

**4. Circle the medications prescribed by Ayse L. Lee-Robinson, M.D. for which you need REFILLS TODAY.**

**5. List any new medications or changes in your medications prescribed by your other doctors (since your last evaluation with Ayse L. Lee-Robinson, M.D.)?** \_\_\_\_\_

**6. Are you noticing any side effects or adverse symptoms that maybe due to your medications? If you are, please list the medication (s) and describe the side effects or adverse symptoms that you are noticing** \_\_\_\_\_

**7. Please list any questions you have for Ayse L. Lee-Robinson, M.D. today** \_\_\_\_\_

\_\_\_\_\_  
**Patient Signature**