TEMPERATURE:_____ RESPIRATORY RATE:_____ HEART RATE:_____ BLOOD PRESSURE:_____

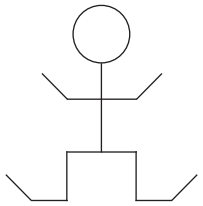
**HISTORY / REVIEW OF SYSTEMS – *A line through both responses indicates "Not Examined"***

| | Positive | Negative | | Positive | Negative | | Positive | Negative |
|---|---|---|---|---|---|---|---|---|
| Fatigue | ❑ | ❑ | Shortness Of Breath | ❑ | ❑ | Back Pain | ❑ | ❑ |
| Headache | ❑ | ❑ | Chest Pain | ❑ | ❑ | Myalgias | ❑ | ❑ |
| Visual Change | ❑ | ❑ | Palpitations | ❑ | ❑ | Rash | ❑ | ❑ |
| Ptosis | ❑ | ❑ | Abdominal Pain | ❑ | ❑ | Anxiety / Depression | ❑ | ❑ |
| Visual Field | ❑ | ❑ | Constipation | ❑ | ❑ | Insomnia | ❑ | ❑ |
| Diplopia | ❑ | ❑ | Diarrhea | ❑ | ❑ | Polyuria | ❑ | ❑ |
| Aphasia | ❑ | ❑ | Nausea Vomit | ❑ | ❑ | Bleeding | ❑ | ❑ |
| Tinnitus | ❑ | ❑ | Incontinence | ❑ | ❑ | Bruising | ❑ | ❑ |
| Dysphagia | ❑ | ❑ | Neck Pain | ❑ | ❑ | | | |

**PHYSICAL**

| | Abnormal | Normal | | Abnormal | Normal | | Abnormal | Normal |
|---|---|---|---|---|---|---|---|---|
| Body Habitus | ❑ | ❑ | Pupils | ❑ | ❑ | Left Arm Motor | ❑ | ❑ |
| Nutrition | ❑ | ❑ | Visual Fields | ❑ | ❑ | Left Leg Motor | ❑ | ❑ |
| Constitutional | ❑ | ❑ | Fundus | ❑ | ❑ | Increased / Decreased Tone | ❑ | ❑ |
| Bruits | ❑ | ❑ | Extra Ocular Movement (EOM) | ❑ | ❑ | Babinski | ❑ | ❑ |
| Heart Rate/Respiratory Rate | ❑ | ❑ | V1-V2-V3 5th Cranial Nerve | ❑ | ❑ | Tremor | ❑ | ❑ |
| Pulses | ❑ | ❑ | Face Symmetry | ❑ | ❑ | Right RSM / RRM (Rapid Alternating) | ❑ | ❑ |
| Skin Temperature | ❑ | ❑ | Hearing Whisper | ❑ | ❑ | Left RSM / RRM (Rapid Alternating) | ❑ | ❑ |
| Edema | ❑ | ❑ | Palate | ❑ | ❑ | Pin | ❑ | ❑ |
| Mental Status | ❑ | ❑ | Shoulder Shrug | ❑ | ❑ | Vibrations | ❑ | ❑ |
| Awake Alert | ❑ | ❑ | Tongue | ❑ | ❑ | JPS (Proprioception) | ❑ | ❑ |
| Oriented x 3 | ❑ | ❑ | Atrophy | ❑ | ❑ | Toe-Heel | ❑ | ❑ |
| Names | ❑ | ❑ | Right Arm Motor | ❑ | ❑ | Axial Balance | ❑ | ❑ |
| Repeats | ❑ | ❑ | Right Leg Motor | ❑ | ❑ | Neglect Left / Right | ❑ | ❑ |
| Follows | ❑ | ❑ | | | | | | |

**DOCUMENTATION SECTION: *PQRI – TPA, CT, A-fib, Swallow, Aspirin, NICS, DVT, Rehab***



| | | |
|---|---|---|
| ❑ Discussed with Nurses | ❑ Discussed with Physicians | ❑ Total Face to Face Time: _____ |
| PMH/FH/SH No Change per ----------> | ❑ Neurology Consult: ____/____/____ | ❑ Counseling Time: _____ |
| | | ❑ Initial History & Physical: ____/____/____ |

**Physician's Signature:** _____ **ID#:**_____ **Date:**_____ **Time:**_____

**LEE MEMORIAL HEALTH SYSTEM**
**Lee County, Florida**

**NEUROLOGY CONSULT SERVICE**

## PROGRESS NOTE

FM# 2943 02/08

**UCO TAB – PROGRESS NOTES**