



## Making the Most of your Neurologist Visit

Every person experiences Parkinson's Disease differently. Being clear and honest about its impact on you and your family is essential to getting the best treatment from your doctor. To maximize your time with your doctor, complete a new copy of this form before each visit and prioritize the topics to discuss. Ask a family member or friend for input and to come with you to the visit. Bring a detailed list of medications and supplements you're taking. Download additional copies at [nmparkinson.org](http://nmparkinson.org)

### Sleep problems

Am I having trouble with:

- |  |              |
|--|--------------|
| 1. Falling asleep or staying asleep    | Yes/No/Maybe |
| 2. Restless Leg Syndrome               | Yes/No/Maybe |
| 3. Feeling uncomfortable when sleeping | Yes/No/Maybe |
| 4. Active vivid dreaming               | Yes/No/Maybe |

### Mood problems

Am I having trouble with:

- |                    |              |
|--------------------|--------------|
| 1. Depression      | Yes/No/Maybe |
| 2. Anxiety         | Yes/No/Maybe |
| 3. Impulse control | Yes/No/Maybe |
| 4. Hallucinations  | Yes/No/Maybe |

### Memory or thinking

Am I having trouble with thinking functions such as memory, concentration, attention, or performing complex tasks Yes/No/Maybe

### Autonomic dysfunction

Am I having trouble with:

- |   |              |
|---|--------------|
| 1. Constipation   | Yes/No/Maybe |
| 2. Bladder control  | Yes/No/Maybe |
| 3. Feeling lightheaded or dizzy especially when standing up | Yes/No/Maybe |
| 4. Sexual function  | Yes/No/Maybe |

### Balance and falls:

- |   |              |
|---|--------------|
| 1. Is my balance worse?                           | Yes/No/Maybe |
| 2. Am I afraid of falling                         | Yes/No/Maybe |
| 3. I have fallen _____ times since my last visit. |              |

Ask your doctor: Are these problems clearly related to Parkinson's or could something else be going on? Is there a specialist I should see to discuss these problems?

Ask yourself: Have I stopped or experienced difficulty doing daily or job related activities, hobbies, sports, etc. because of Parkinson's? Yes / No If yes, please list.

#### Parkinson's rehabilitative therapies

Have I been treated by a physical therapist, occupational therapist or speech and swallowing therapist in the past year? Yes / No / Not sure

#### Parkinson's related safety issues and counseling

1. Am I concerned about falls or moving safely in my home or community? Yes / No / Not sure
2. Am I or my family concerned about my driving? Yes / No / Not sure
3. Do I have trouble keeping track of my medicines, taking them on time or understanding how and why I need to take them? Yes / No / Not sure

#### Medicine related motor complications

1. Does my medicine wear off between doses? Yes / No / Not sure
2. Are there times of the day that my medicine does not work? Yes / No / Not sure  
If yes, on average how long does each dose last? \_\_\_\_\_Hours
3. Does my body move when I am not aware of it? Yes / No / Not sure

#### Medical, surgical and other treatment questions to discuss

1. Do my medications need to be adjusted?
2. Is surgery an appropriate option for me?
3. Can you suggest any complementary, rehabilitative, or other therapies that could help me?
4. Is there a support group or counselor that you recommend?

## QUESTIONS ABOUT MY TREATMENT PLAN

What are my current or most bothersome symptoms (tremor, stiffness, slowness, balance, other)?

Did I make the changes recommended at my last visit?

Were my last treatment changes helpful? Explain.

Do I have any new medical problems or allergies since my last visit?

What prescriptions do I need refilled?