

CURRENT SYMPTOMS SUMMARY

Name: _____ Date: _____

This document will summarize your problems or concerns, improving your team's understanding of you and your Parkinson's and helping them to effectively tailor your treatment.

I have trouble in the following areas that may be affected by my treatment, hospital stay or procedure:

Motor Problems

- Balance problems
- Communication and speech difficulties
- Dyskinesia - uncontrollable movements usually caused by medication
- Dystonia - involuntary muscle spasm, contraction leading to pain, flexion or twisting movements
- Freezing of gait or motor initiation problems (feet stuck to floor)
- "On/off" fluctuations - periods of time when my medications are "on" that I can move better and when my medications are "off" and I have difficulty moving. "Off" periods usually happen as my medication is wearing "off." To reduce this problem, **I must have my Parkinson's medications on time.**
- Swallowing problems

Non-Motor Problems

- Anxiety
- Apathy or trouble self-initiating tasks
- Bladder problems
- Constipation
- Depression



- Cognitive problems
 - Memory problems or mild thinking difficulties
 - Dementia
 - Hallucinations or sensitivity to hallucinations with certain medications
- Drooling
- Excessive sweating or chills
- Fatigue
- Impulsivity problems
- Loss of smell or loss of appetite
- Pain in these areas: _____
- Sleep problems
 - Trouble staying asleep
 - Restless legs syndrome
 - Periodic limb movement disorder: repetitive movements, typically of the legs and feet
 - Sleep apnea
 - REM sleep behavior disorder: vivid, active, physical dreaming
 - Daytime sleepiness
- Sensations such as tingling, aches, pain, cold hands/feet
- Sexual dysfunction
- Vision problems