Solutions Pharmacy
Compounding you can Trust

Patient Follow-Up Survey

Patient name: _____ Phone: _____Date:_____

Please answer the following questions:

1. Circle which form you are taking: Capsules or RDT's or Liquid Solution
2. What is your current dose? _____mg ***(circle one)*** 1/Nightly 1/daily twice/daily
3. What was your LDN start date? _____/_____/_____
4. Describe your health issues prior to LDN. (Diagnosis: i.e. COVID-19, Fibromyalgia, Hashimoto's, Lupus, Lyme's, Rheumatoid Arthritis,…ect)_____
5. How long had you been suffering before learning about LDN? _____ months _____ years
6. What were your top 5 complaints _____ _____
   _____ _____ _____
7. Rate your pain before beginning on LDN (on a scale of 1-10 with 10 being excruciating pain) _____
8. Describe your overall health since starting on LDN.
   _____
9. Rate your pain since starting on LDN (on a scale of 1-10 with 10 being excruciating pain) _____
10. Do you have any questions or concerns that you need to address with a pharmacists? Yes or No
11. Have you had any side effects while taking LDN? Yes or No If so what?
    _____
12. Has LDN helped with symptom relief? Yes or No or Somewhat
13. Please rate the symptoms both pre and post LDN use:

(1-10 with 10 being the worse) (Check if better)

Health Issue	Pre LDN Use	During LDN Use	√ Better w/LDN Use
Bladder Urgency			
Bladder Retention			
Sexual Dysfunction			
Bowel Control			
Constipation			
Memory/Concentration			
Depression			
Dizziness			
Mobility			
Muscle Spasm			
Muscle Strength			
Fatigue			
Restless Legs			
Sleep Disturbance			
Migraine Headaches			
Blurred Vision/Double Vision			
Itching			
Numbness			
Tingling extremities			