Follow up Questionnaire

Appointment Date: ______________________

Name: ___________________________ Date of Birth: _______________________
Phone Number: ____
Is it ok to leave a detailed message (please circle) Yes No
Preferred Email Address: ____
Emergency Contact and Phone Number: ___________________________________
Height ___________________ (ft/inches) Weight ___________ Lbs
Physician's name (s) who should receive medical information from us:
____
____
What is the reason for today's visit?
____
____

Please complete the following..
Since your last visit, has there been a change in your:
MEDICAL CONDITIONS
☐ No change

Please list (ie. High blood pressure, heart disease, kidney disease, diabetes, etc)
____
____
____
____
____

SURGICAL HISTORY
☐ No change
Operation _________________________ Date ___________________
Operation _________________________ Date ___________________
Operation _________________________ Date ___________________

MEDICATION REGIMEN
☐ No change

Name, dose, and use ____
Name, dose, and use ____
Name, dose, and use ____
Name, dose, and use ____
Name, dose, and use ____
Name, dose, and use ____

MEDICATION ALLERGIES AND REACTION
☐ No change

Please list any changes.
____
____

REVIEW OF SYSTEMS
(Circle No or Yes to Each Question Please)

CONSTITUTIONAL SYMPTOMS

Good general health lately …………….............. No / Yes
Recent weight change .... No / Yes
(gain or loss – circle one)

Fever.. No / Yes
Fatigue…………………………………………… No / Yes

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing...................................... No / Yes
Earaches or drainage....................................... No / Yes
Chronic sinus problem or rhinitis...................... No / Yes
Nose bleeds.. No / Yes
Mouth sores.. No / Yes
Bleeding gums.. No / Yes
Sore throat or voice change .... No / Yes
Swollen glands in neck..................................... No / Yes

EYES

Eye disease or injury.. No / Yes
Blurred or double vision.................................... No / Yes
Glaucoma... No / Yes
Cataracts.. No / Yes

RESPIRATORY

Asthma or Wheezing... No / Yes
COPD or Emphysema....................................... No / Yes
Chronic or frequent coughs............................... No / Yes
Snoring or Sleep Apnea................................... No / Yes
Shortness of breath.. No / Yes
Coughing up blood... No / Yes

ENDOCRINE

Thyroid Disease.. No / Yes
Glandular or hormonal problems...................... No / Yes
Diabetes (insulin or noninsulin – circle) .... No / Yes
Excessive Thirst.. No / Yes
Cold or Heat intolerance................................... No / Yes
Excessive Urination.. No / Yes

NEUROLOGIC

Frequent or Recurring headaches.................... No / Yes
Lightheaded or Dizziness................................. No / Yes
Paralysis... No / Yes
Stroke or TIA – When?_______........................ No / Yes
Head Injury? .... No / Yes

CARDIOVASCULAR

High blood Pressure (Hypertension)...... No / Yes
Heart Attack... No / Yes
Cardiac Stents?........................ No /Yes
Heart Murmur……………………………… No / Yes
Congestive Heart Failure....................................... No / Yes

Palpitations.. No / Yes

HEMATOLOGIC/LYMPHATIC

Do you regularly use blood thinners? .... No / Yes
(Aspirin, Coumadin, Plavix, Lovenox)
Slow to heal after cuts........................... No / Yes
Bleeding or bruising tendency Anemia... No / Yes
Past transfusion.................................... No / Yes

PSYCHIATRIC

Memory loss or confusion .... No / Yes
Nervousness/Anxiety............................. No / Yes
Depression.. No / Yes

INTEGUMENTARY (skin, breast)

Nonhealing Wounds or Sores................ No / Yes
Rash or itching .... No / Yes
Change in skin color.............................. No / Yes
Change in hair or nails........................... No / Yes
History of Breast Cancer........................ No / Yes

MUSCULOSKELETAL

Arthritis.. No / Yes
Muscle pain or cramps.......................... No / Yes
Leg Pain with walking............................ No / Yes
Leg Pain with Rest................................. No / Yes
How many blocks can you walk before you have pain? _____

GASTROINTESTINAL

Hepatitis or Liver Disease GERD.......... No / Yes
Nausea or vomiting................................ No / Yes
Frequent diarrhea.................................. No / Yes
Abdominal pain...................................... No / Yes
Peptic ulcer (stomach or duodenal)........ No / Yes

GENITOURINARY

Blood in urine... No / Yes
Kidney stones.. No / Yes
Kidney (renal) insufficiency..................... No / Yes

****** NURSING USE ONLY****DO NOT FILL OUT BELOW THIS LINE *********

Vitals: HR ____ BP____/____ Pulse Ox____% RR ___ Temp _______

PULSES/PRESSURES

Right		Left	
BRACHIAL		BRACHIAL	
DP		DP	
PT		PT	

ABI RIGHT:___________ ABI LEFT: ___________

LABS

Date Collected ____________________

Hemoglobin		INR Total	
WBC		Total Bilirubin	
Platelets		AST	
Creatinine		ALT	

Physician Exam / History notes: