

**FOLLOW-UP PATIENT FORM**  
**(To be completed by patients who have not been seen in over 3 months)**

Name \_\_\_\_\_ DOB \_\_\_\_\_

Today's date \_\_\_\_\_

Phone# (home) \_\_\_\_\_ (work or cell) \_\_\_\_\_

When was your last visit here? \_\_\_\_\_

Referring or primary care physician \_\_\_\_\_ phone# \_\_\_\_\_

List any hospitalizations, surgery or other major illness since last visit

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

Any recent heart tests?    Echo (cardiac ultrasound)    Stress test  
 Nuclear stress test    Cath   Date performed \_\_\_\_\_

Current medication	Dosage	Frequency (how often)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current allergy list  
\_\_\_\_\_

Do you have any specific questions for your doctor?  
\_\_\_\_\_

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**Patient Name** \_\_\_\_\_

**Date** \_\_\_\_\_

**CONSTITUTIONAL**

Good general health lately      No    Yes  
Recent weight change            No    Yes  
Fevers/chills                        No    Yes

**NEUROLOGICAL**

Frequent or recurring headaches      No    Yes  
Light headed or dizzy                    No    Yes  
Numbness or tingling sensations        No    Yes

**RESPIRATORY**

Frequent coughing                    No    Yes  
Shortness of breath                  No    Yes  
Asthma or wheezing                  No    Yes

**PSYCHIATRIC**

Nervousness/anxiety                  No    Yes  
Depression                              No    Yes

**EYES**

Wear glasses/contact lens            No    Yes  
Blurry vision                          No    Yes

**HEMATOLOGICAL/LYMPHATIC**

Easily bruise or bleed                No    Yes  
Anemia                                  No    Yes  
Swollen glands                         No    Yes  
Previous blood transfusions         No    Yes

**ENT**

Sinus problems                        No    Yes  
Sore throat or voice change         No    Yes

**GASTROINTESTINAL**

Loss of appetite                        No    Yes  
Change in bowel movement          No    Yes  
Nausea or vomiting                    No    Yes  
Blood in stool                          No    Yes  
Stomach pain, indigestion            No    Yes

**URINARY**

Frequent urination                    No    Yes  
Burning or painful urination         No    Yes  
Blood in urine                         No    Yes  
Sexual difficulty                        No    Yes

**MUSCULOSKELETAL**

Joint pain                                No    Yes  
Muscle pain or cramps                No    Yes  
Back pain                                No    Yes

**SKIN**

Rash or itching                         No    Yes  
Varicose veins                         No    Yes

**ENDOCRINE**

Excessive thirst or urination        No    Yes  
Heat or cold intolerance              No    Yes

**CIRCULATION**

Do you have any discomfort or aching in the muscles of your legs, arms, thighs or buttock when you walk that is relieved by rest?      No    Yes

Do your legs ever feel fatigued or heavy when walking or are active?      No    Yes

Do you ever need to stop and rest when walking or have difficulty keeping up with others?      No    Yes

Do your feet or toes bother you at night?      No    Yes

Do you have any painful sores or ulcers on your legs or feet that aren't healing?      No    Yes

Have you experienced TEMPORARY: Loss of vision in one eye? No Yes  
Slurred speech? No Yes  
Weakness or numbness of an arm or leg on  
one side of your body? No Yes

Have you had surgery, balloon procedures, or stents to any blood vessels other than  
your heart? Explain: No Yes

Have you had blockages in your coronary arteries? No Yes

Do you have a history of, or take medication for any of the following?  
{ } Diabetes or "borderline" diabetes? { } Smoking or history of { } High cholesterol