Follow-up Patient Questionnaire

NAME: _________________________________ Date: ___________________ DOB: ________________

What is the main reason for your visit today? ☐ Routine follow-up ☐ New problem

If this is a new problem, please describe: ____

IF YOU HAVE REVIEWED THE QUESTIONS BELOW AND THERE ARE NO CHANGES
SINCE YOUR LAST VISIT, PLEASE CHECK HERE ☐

UPDATE ON PAST MEDICAL HISTORY: (New problems or changes since last office visit)

New medications or medication allergies: ☐ No ☐ Yes, please list/describe

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New medical problems, hospitalizations, surgeries: ☐ No ☐ Yes, please describe

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Change in social situation: ☐ No ☐ Yes, please describe

____

Change in smoking status or alcohol consumption: ☐ No ☐ Yes, please describe

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New health problems in close family members: ☐ No ☐ Yes, please describe

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REVIEW OF SYSTEMS: (please check if you have had and any of these symptoms since your last appointment)

- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Unintended weight loss
- ☐ Fatigue
- ☐ Rashes
- ☐ Ringing in ears
- ☐ Decreased hearing
- ☐ Headaches
- ☐ Dizziness
- ☐ Visual problems
- ☐ Dry eyes
- ☐ Dry mouth
- ☐ Hoarseness
- ☐ Shortness of breath
- ☐ New/increased numbness in extremities
- ☐ Nausea
- ☐ Swallowing problems
- ☐ Blood in stool
- ☐ Black/tarry stool
- ☐ Constipation
- ☐ Trouble urinating
- ☐ Blood in urine
- ☐ Depression
- ☐ Irritability
- ☐ Seizures
- ☐ Abnormal bruising/bleeding
- ☐ Morning stiffness: how long? ___________
- ☐ Mouth sores
- ☐ Cough
- ☐ Stomach pain

Reviewed by physician: ____________________________________ Date: __________________________