Return Visit Form

Name_____
Date of Birth_____Age_____
Please list any change in Insurance:_____
_____
_____

Please list your Copay:_____

Please list change of address or phone number:
_____
_____
_____

Any Hospitalizations/Illnesses since last appointment? Please describe-what/where/when?
_____
_____
_____

Please list any change in your medications since last vist:_____
_____
_____
_____

Are you taking OTC pain meds, Herbal Meds or recieved IV dye since last visit? (if yes please list):
_____
_____
_____

Any surgeries since last appointment? Describe.
_____
_____

Immunizations—date received if completed
Pneumovax _____
Flu vaccine_____
Preventative-date/year performed if completed
Mammogram_____
Colonoscopy_____

Please Circle "Yes" or "No" to any of the following symptoms that are NEW to you:

GENERAL
Yes No Chills or Fever
Yes No Poor Appetite
Yes No Weight Loss/Weight gain
Yes No Loss of energy

LUNGS
Yes No Cough
Yes No Coughing up blood
Yes No Shortness of breath
Yes No Wheezing
Yes No Shortness of breath with activity

HEART
Yes No Chest Pain or Pressure
Yes No Heart Palpitations
Yes No Irregular heart beat
Yes No Waking up with shortness of breath
Yes No Using several pillows to sleep
Yes No Swelling of legs, ankles or feet
Yes No Pain in calves when walking

STOMACH/INTESTINES
Yes No Difficulty/Painful swallowing
Yes No Stomach discomfort/pain
Yes No Heartburn/indigestion
Yes No Nausea or vomiting
Yes No Vomiting blood
Yes No Blood in stools
Yes No Constipation
Yes No Chronic Diarrhea
Yes No Laxatives use
Yes No Black, tarry stools

MEN
Yes No Prostate problems
Yes No Weak or slow urinary stream

URINARY
Yes No Blood in urine
Yes No Pain on urination
Yes No Urine infection
Yes No Incontinence
Yes No Kidney stone

NERVOUS SYSTEM
Yes No Severe headaches
Yes No Dizziness or Lightheadedness
Yes No Loss of balance
Yes No Seizures
Yes No Passing out or fainting
Yes No Numbness or tingling

BONES/MUSCLES/JOINTS
Yes No Back Pain
Yes No Painful Joints
Yes No Swelling of the joints
Yes No Stiff joints
Yes No Muscle Aches or weakness

SKIN
Yes No Skin rash
Yes No Itching excessively

BLOOD
Yes No Blood Loss
Yes No Have you had a blood transfusion

PSYCHIATRIC
Yes No Mood Swings
Yes No Depression
Yes No Anxiety
Yes No Sleep problems
Yes No Memory Loss

Other issues_____
_____
Signature:_____Date: ____