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Follow-Up Visit Questionnaire

REGISTRATION DATA:

Since your last visit to this office, have you:

changed names?	Yes	_____	No	_____
moved?	Yes	_____	No	_____
changed contact numbers?	Yes	_____	No	_____
changed jobs?	Yes	_____	No	_____
changed insurance company?	Yes	_____	No	_____
changed doctors?	Yes	_____	No	_____
changed pharmacy	Yes	_____	No	_____
changed lab	Yes	_____	No	_____

Do you want to change the contact for emergencies encountered during the office visit?

Yes _____ No _____ If yes please provide new contact _____.

If you answered yes to any of these questions please provide the new information below.

HISTORY DATA:

Since your last visit to this office, has your/ have you:

Been admitted to a hospital?	Yes	_____	No	_____
Gone to an emergency room?	Yes	_____	No	_____
Changed your medications?	Yes	_____	No	_____
Received any surgery?	Yes	_____	No	_____
Has your overall health				
become worse?	Yes	_____	No	_____
New medical problems or				
disease diagnosis?	Yes	_____	No	_____
Your allergies changed?	Yes	_____	No	_____

Has your medical condition that you saw our practice for on your last visit changed?
Yes _____ No _____ If yes, please explain in your own word how it has changed?

Are you seeing us for the same problem? Yes _____ No _____
If no, please explain your new problem below.

For Males Only:

Have your male sexuality issues changed? Yes _____ No _____
Have you had a more recent PSA test? Yes _____ No _____
If yes, provide value and date: _____

For Females Only:

Have you had any additional children? Yes _____ No _____
Any recent miscarriages? Yes _____ No _____
Any new female organ problems? Yes _____ No _____
Any new female sexuality issues? Yes _____ No _____
Do you now leak urine? Yes _____ No _____

When was your last menstrual period? _____

******COULD YOU BE PREGNANT AT THIS TIME? Yes _____ No _____**

REVIEW OF SYSTEMS:

Do you have any other general systemic symptoms such as:

Fever and/or chills?	Yes _____	No _____
Nausea or vomiting?	Yes _____	No _____
Diarrhea?	Yes _____	No _____
Constipation?	Yes _____	No _____
Headache?	Yes _____	No _____
Weight loss?	Yes _____	No _____
Night sweats?	Yes _____	No _____
New onset bone pain?	Yes _____	No _____
Recent chest pain?	Yes _____	No _____
Recent episode of shortness of breath?	Yes _____	No _____

Head, ears, nose and throat problems? Yes _____ No _____

Any lumps in your neck?	Yes _____	No _____
Frequent infections?	Yes _____	No _____
Any eyesight problems?	Yes _____	No _____
Any hearing problem?	Yes _____	No _____
Any dizziness?	Yes _____	No _____

Any problems with your lungs or breathing? Yes _____ No _____
Shortness of breath? Yes _____ No _____
Asthma? Yes _____ No _____
Wheezing? Yes _____ No _____
Gurgling sounds? Yes _____ No _____
Ever cough up blood? Yes _____ No _____
Ever have pneumonia? Yes _____ No _____
Any others? Yes _____ No _____
Explain:

Any problems with your heart? Yes _____ No _____
Any heart attacks? Yes _____ No _____
How many and when? _____
Any chest pain/angina? Yes _____ No _____
Chest Pain with exertion? Yes _____ No _____
Indigestion? Yes _____ No _____
Heartburn? Yes _____ No _____
Radiation of pain to
neck or arms? Yes _____ No _____

Any problems with your gastrointestinal system? Yes _____ No _____
Nausea, vomiting? Yes _____ No _____
Diarrhea, constipation? Yes _____ No _____
Rectal bleeding? Yes _____ No _____
Vomit coffee grounds? Yes _____ No _____
Blood in toilet after BM? Yes _____ No _____
Ulcers? Yes _____ No _____
Gastritis? Yes _____ No _____
Heartburn? Yes _____ No _____
Acid reflux? Yes _____ No _____

Any problems with your male or female organs? Yes _____ No _____
Any problems with your muscles or joints? Yes _____ No _____
Any problems with your brain or neurological system? Yes _____ No _____
Any vascular problems? Yes _____ No _____
Pain in extremities with activity? Yes _____ No _____
Varicose veins? Yes _____ No _____

**IF THERE IS ANYTHING ELSE IN YOUR MEDICAL HISTORY THAT YOU
THINK YOUR DOCTOR SHOULD BE AWARE OF NOT INCLUDED ABOVE
PLEASE LIST IT HERE:**

I read the above questionnaire and this information is true to the best of my knowledge.

Patient Signature: _____ Date: _____