

FOLLOW-UP VISIT HISTORY FORM

PATIENT INFORMATION

Name _____ Title _____

Race _____ Preferred Language _____ Email _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Patient declines to specify

Contact Preference: Letter Phone Patient Portal/Email Patient declines to specify

I would like to receive preventive care and follow-up care reminders: Yes No

Our Patient Portal allows you to communicate with our practice and review your medical history.

Please click yes to indicate you consent to access information on line: Yes No

I consent to obtaining a history of my medications purchased at pharmacies: Yes No

Pharmacy:

Name: _____ Address: _____ Phone: _____

Name: _____ Address: _____ Phone: _____

ALLERGIES

No known allergies No known drug allergies Other Allergies _____

Codeine IV Contrast Latex Penicillin _____

IMMUNIZATIONS

None

Flu Vaccine Hep A Hep B Pneumococcal Other _____

SOCIAL HISTORY

Occupation _____

Number of Children _____

MARITAL STATUS

Single Married Divorced Separated Widowed Civil Union Other

ALCOHOL None Social Daily Quit

TOBACCO Current every day smoker Current some day smoker Former smoker Never smoked

Smoker, current status unknown Light tobacco smoker Heavy tobacco smoker Unknown if ever smoked

Other _____

Please complete the other side.

ARE YOU CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS?

GASTROINTESTINAL

<input type="checkbox"/> NONE	YES	NO
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Belching	<input type="checkbox"/>	<input type="checkbox"/>
Black stool	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>
Change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Gas	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Hiccups	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>
Milk/lactose intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Pain with bowel movement	<input type="checkbox"/>	<input type="checkbox"/>
Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Rectal itching	<input type="checkbox"/>	<input type="checkbox"/>
Rectal pain	<input type="checkbox"/>	<input type="checkbox"/>
Stomach burning	<input type="checkbox"/>	<input type="checkbox"/>
Stool incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Trouble swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>

CARDIOVASCULAR

<input type="checkbox"/> NONE	YES	NO
Angina/chest pressure	<input type="checkbox"/>	<input type="checkbox"/>
Ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>

CONSTITUTIONAL

<input type="checkbox"/> NONE	YES	NO
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Sweats	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>

ENMT

<input type="checkbox"/> NONE	YES	NO
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>
Burning tongue	<input type="checkbox"/>	<input type="checkbox"/>
Change in vision	<input type="checkbox"/>	<input type="checkbox"/>
Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>

ENDOCRINE

<input type="checkbox"/> NONE	YES	NO
Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>
Hair change	<input type="checkbox"/>	<input type="checkbox"/>
Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>

GENITOURINARY

<input type="checkbox"/> NONE	YES	NO
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Change in urinary frequency	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty w/ urination	<input type="checkbox"/>	<input type="checkbox"/>
Irregular menstruation	<input type="checkbox"/>	<input type="checkbox"/>
Sexual difficulty	<input type="checkbox"/>	<input type="checkbox"/>

HEMATOLOGIC/LYMPHATIC

<input type="checkbox"/> NONE	YES	NO
Enlarged glands	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>

SKIN

<input type="checkbox"/> NONE	YES	NO
Itching	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>

MUSCULOSKELETAL

<input type="checkbox"/> NONE	YES	NO
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>
Stiff joints	<input type="checkbox"/>	<input type="checkbox"/>
Swollen joints	<input type="checkbox"/>	<input type="checkbox"/>

NEUROLOGICAL

<input type="checkbox"/> NONE	YES	NO
Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>

RESPIRATORY

<input type="checkbox"/> NONE	YES	NO
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>

PSYCHIATRIC

<input type="checkbox"/> NONE	YES	NO
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>
Memory loss/confusion	<input type="checkbox"/>	<input type="checkbox"/>