Established Patient Follow Up Questionnaire

Chief Complaint: What is your main problem today?

_____

History of Present Illness: Compared to your last visit are you ☐ Better ☐ Worse ☐ Same
Have there been any recent changes in your health? ☐ No ☐ Yes If yes, please describe.

_____

_____

Do you need a medication refill? ☐ Yes ☐ No Medication Name: _____ Dose: _____
☐ 30 day ☐ 60 day ☐ 90 day
Are you currently on oxygen or have you ever been? ☐ Yes ☐ No

PERSONAL HISTORY: Please mark all applicable problems.

GENERAL:
☐ Weight Gain
How much? _____
☐ Weight loss
How much? _____
☐ Fever
☐ Night Sweats
☐ Chills

EYES:
☐ Glasses or contacts
☐ Vision loss
☐ Glaucoma
☐ Eye pain

EAR, NOSE & THROAT:
☐ Loss of hearing
☐ Sinus problems
☐ Postnasal drainage
☐ Frequent throat clearing
☐ Persistent hoarseness
☐ Ear infection
☐ Throat infection

HEMATOLOGIC:
☐ Easy bruising
☐ Abnormal bleeding
☐ History of blood clots
☐ Anemia

HEART & VASCULAR:
☐ Palpitations
☐ Swelling in legs
☐ Pain with walking

RESPIRATORY:
☐ Chest pain
☐ Frequent cough
☐ Wheezing
☐ Coughing up sputum
☐ Coughing up blood
☐ Shortness of breath at rest
☐ Shortness of breath walking on level ground
☐ Shortness of breath walking up hill or stairs

PSYCHIATRIC:
☐ Depression
☐ Nervousness

ENDOCRINE:
☐ Steroids within the last two weeks (injections or pills)

GASTROINTESTINAL:
☐ Difficulty swallowing
☐ Frequent heartburn
☐ Nausea
☐ Diarrhea

GENITOURINARY:
☐ Frequent urination
☐ Difficulty starting stream
☐ Difficulty emptying bladder

MUSCULOSKELETAL:
☐ Back pain
☐ Painful joints
☐ Swollen or red joints

NEUROLOGICAL:
☐ Frequent headaches
☐ Severe headaches
☐ Dizziness
☐ Weakness
☐ Numbness

Are you currently using tobacco? ☐ Yes ☐ No
☐ Smokeless tobacco ☐ Cigarettes

If you are over age 65, have you ever received the pneumonia vaccine? ☐ Yes ☐ No

Have you received the flu vaccine September-February this flu season? ☐ Yes ☐ No