

Patient Follow-up Visit Questionnaire

Your Name: _____ Date: _____ Age: _____

Your Family Doctor: _____ Acct: _____ DOB: _____

1. SINCE YOUR LAST VISIT: Have you experienced (circle YES or NO)

- YES NO Chest Pressure/Pain? _____
- YES NO Shortness of Breath? _____
- YES NO Palpitations? _____
- YES NO Lightheadedness or Dizziness? _____
- YES NO Waking spells at night due to breathing difficulty? _____
- YES NO Swelling in Legs? _____
- YES NO Near Blackout or Blackouts? _____
- YES NO Fatigue or Weakness? _____
- YES NO Pain or cramps in calves or buttocks when walking? _____
- YES NO Do you smoke? If yes, how many packs/day _____
- YES NO Do you exercise? If yes, what type? _____

2. SINCE YOUR LAST VISIT: Have you experienced (circle YES & describe)

- YES NO Have you been hospitalized? _____
- YES NO Have you had any change in occupational status? _____
- YES NO Depression or psychiatric condition? _____
- YES NO Any symptoms of Stroke, Weakness or Numbness? _____
- YES NO Problems with sexual function? _____
- YES NO Problems with kidneys? _____
- YES NO Problems with urination? _____
- YES NO Change in bowel habits, abdominal pain? _____
- YES NO Wheezing, Coughing? _____
- YES NO Sore throat? _____
- YES NO Any problems with hearing? _____
- YES NO Any problems with vision? _____
- YES NO New ulcers or sores? _____
- YES NO Bruising or bleeding? _____
- YES NO Fever, chills or night sweats? _____
- YES NO Recent weight loss or gain? _____

3. Any new medical or surgical problems or other new symptoms since your last visit?

4. Please list your current medications (please include dose and how often you take them)

_____	_____
_____	_____
_____	_____

Please list any drug allergies:

HT: _____ ft _____ inches WT: _____ BMI: _____ Pain: _____

L arm BP: _____ / _____ R arm BP: _____ / _____ P: _____ RR: _____

DOCTOR'S SIGNATURE

Date: