RETURN PATIENT VISIT

Name: __________________________________________ Age: ______ Date: __________

Patient E-mail Address: ____________________________________________________________________________

Pharmacy Name: __________________________________ Phone Number: ______________________

Why did you come to see the doctor today?

Have you developed any new medical problems since your last visit? □ Yes □ No

If yes, please list: _________________________________________________________________________________

List all current medications: _______________________________________________________________________

__________________________________________________________________________________________________

Name of Primary Care Physician: __________________________________________

Has your family developed any new medical problems since your last visit? □ Yes □ No

If yes, please list: _________________________________________________________________________________

REVIEW OF SYSTEMS (please check all that apply to you today)

Skin

☑ Normal □ Rash □ Ulcers

Neurological

☑ Normal □ Seizures □ Neuropathy

☐ Syncope / Pass Out

Psychiatric

☑ Normal □ Depression

Endocrine

☑ Normal □ Diabetes □ Thyroid Disease □ Hot Flashes

Urinary

☑ Normal □ Blood in Urine □ Pain on Urination

☐ Leakage of Urine □ Urgency to Void

Genital

☑ Normal □ Abnormal Bleeding □ Vaginal Discharge □ Breast Pain

Sex Function

☑ Normal □ Painful Intercourse □ Bleeding after Intercourse □ Lack of Desire

Hematology

☑ Normal □ Easy Bruising □ Spontaneous Bleeding

☑ Enlarged Lymph Nodes

Allergy

☑ Normal □ Seasonal Allergies □ Drug Allergies

General

☑ Normal □ Weight Loss □ Fatigue

Eyes

☑ Normal □ Change in Vision

Ears/Mouth

☑ Normal □ Problems Hearing □ Ulcers □ Sore Throat

Cardiovascular

☑ Normal □ Chest Pain □ Shortness of Breath with Exercise

☐ Shortness of Breath in Bed

Respiratory

☑ Normal □ Shortness of Breath □ Wheezing

☐ Respiratory Infection (cold)

Gastrointestinal

☑ Normal □ Nausea/Vomiting □ Diarrhea □ Blood Stools

Musculoskeletal

☑ Normal □ Muscle Weakness □ Arthritis

HealthCare Screening Tests: (please list date and result of most recent test)

Pap Test: ___________________ Mammogram: ___________________ Colonoscopy: ___________________

Patient Signature: __________________________________________ Date: ______________

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