

Patient follow up

Patient Name _____

Please document any changes in your medications, new medical problems or surgeries, or new symptoms since last visit

New Medical Problems: _____

No Change

Recent Surgeries: _____

No Change

Allergies: _____

Current Medications: _____

Review of Systems:

General:

- change in sleep habits
- chills
- fatigue
- fever
- night sweats
- weight gain
- weight loss
- Other
- NONE

Gastrointestinal:

- yellow skin or eyes
- nausea/vomiting
- problems swallowing
- cramping/stomach pain
- indigestion
- reflux
- diarrhea
- constipation
- black stool
- blood in stool
- other
- NONE

Skin:

- open sore
- change in moles
- abnormal color
- rashes
- other
- NONE

Head & Neck:

- hoarseness
- nosebleeds
- sore throat
- sores in mouth or throat
- other
- NONE

Neurological:

- memory changes
- numbness/tingling
- dizziness/fainting
- weakness
- blurred vision
- headache
- ringing in ears
- seizures
- speech changes
- other
- NONE

Cardiovascular:

- chest pain
- fast heart beat
- other
- NONE

Genitourinary/Breast:

- burning
- frequency
- blood in urine
- dribbling
- unable to control bladder
- problems with passing urine
- enlarged prostate
- urinary incontinence
- unusual bleeding/discharge
- breast changes
- breast lumps
- nipple discharge
- birth control
- other
- NONE

Psychological:

- worried/anxious
- sad/depressed
- other
- NONE

Respiratory:

- wheezing
- cough
- short of breath
- bloody phlegm/sputum
- other
- NONE

Hematologic/Lymphatic:

- abnormal bleeding
- lymphedema
- easy bruising
- history of DVT/PE
- prior transfusion
- swelling in groin/arm/pit
- other
- NONE

Endocrine:

- cold intolerance
- hot flashes
- other
- NONE

Musculoskeletal: (other than reason for visit)

- joint swelling
- joint/back pain
- stiffness
- trauma
- falls
- other
- NONE