Follow-up Appointment

Date: ______________ Name: _________________________________ DOB: ____________________

Has your contact/insurance information changed since your last visit? **YES** **NO**

Note changes here: ____

Do you have any new family history to add to your chart? **YES** **NO**

Note changes here: ____

*Current concerns and response to treatment:*____
____
____
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Current medications and supplements: ____
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Preventative screening: Please list date of last screening below, if applicable.

Mammogram:____________ Colonoscopy:____________ Dexa Scan:______________

*Rate each of the following symptoms based upon your typical health profile for the **past 14 days**.*

Point Scale

0- ***Never or almost never*** have the symptom
1- ***Occasionally*** have it, effect is ***not severe***
2- ***Occasionally*** have it, effect is ***severe***
3- ***Frequently*** have it, effect is ***not severe***
4- ***Frequently*** have it, effect is ***severe***

Head

____ Headaches
____ Faintness
____ Dizziness
____ Insomnia

Total __________

Eyes

____ Watery or itchy eyes
____ Swollen, reddened or sticky eyelids
____ Bags or dark circles under eyes
____ Blurred or tunnel vision

Total __________

Ears

____ Itchy ears
____ Earaches, ear infections
____ Drainage from ear
____ Ringing in ears, hearing loss

Total __________

Nose

____ Stuffy nose
____ Sinus problems
____ Hay fever
____ Sneezing attacks
____ Excessive mucus formation

Total __________

Mouth/Throat

____ Chronic coughing
____ Gagging, frequent need to clear throat
____ Sore throat, hoarseness, loss of voice
____ Swollen or discolored tongue, gums, lips
____ Canker sores

Total__________

Skin

____ Acne
____ Hives, rashes, dry skin
____ Excessive sweating

Total__________

Heart

____ Irregular or skipped heartbeat
____ Rapid or pounding heartbeat
____ Chest pain

Total__________

Lungs

____ Chest congestion
____ Asthma, bronchitis
____ Shortness of breath
____ Difficulty breathing

Total__________

Digestive Tract

____ Nausea, vomiting
____ Diarrhea
____ Constipation
____ Bloated feeling
____ Belching, passing gas
____ Heartburn
____ Intestinal/stomach pain

Total__________

Joint/Muscle

____ Pain or aches in joints
____ Arthritis
____ Stiffness/ limitation of movement
____ Pain or aches in muscles
____ Feeling of weakness or tiredness

Total__________

Weight

____ Binge eating/drinking
____ Craving certain foods
____ Excessive weight
____ Compulsive eating
____ Water retention
____ Underweight

Total__________

Energy/Activity

____ Fatigue, sluggishness
____ Apathy, lethargy
____ Hyperactivity
____ Restlessness

Total_________

Mind

____ Poor memory
____ Confusion, poor comprehension
____ Poor concentration
____ Poor physical coordination
____ Difficulty in making decisions
____ Stuttering or stammering
____ Slurred speech
____ Learning disabilities

Total__________

Emotions

____ Mood swings
____ Anxiety, fear, nervousness
____ Anger, irritability, aggressiveness
____ Depression

Total__________

Sex Hormones

____ Hot flashes
____ Low libido
____ Insomnia
____ Poor muscle tone
____ Vaginal irritation/dryness
____ Vaginal bleeding
____ Breast tenderness
____ Breast lump

Total__________

____Poor Circulation
____ Brain fog
____ Weight gain
____ Weight loss
____ Cold intolerance
____ Hair loss
____ Skin dryness

Total_________

Other

____ Frequent illness
____ Frequent or urgent urination
____ Genital itch or discharge

Total__________

Grand Total_________

Completed by Nurse/Medical Assistant: (for office use only)

Vital signs:

Height____________________ Weight____________________
Blood Pressure______________ Temperature________________
Pulse_______________________

Completed by Provider:

Physical exam:

Constitutional____________________________ GI: ______________________________________
HEENT: ___________________________________ GU: _____________________________________
Cardiac: __________________________________ Psych/Neuro: ____________________________
Pulmonary: _______________________________ Breast: __________________________________

Assessment and Plan:

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Labs____
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Follow up____
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CPT Code:______________________ Time Spent w/ pt.:_______________

Signature___________________________________ Date____________________________