**Returning Patient Form**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please circle all symptoms you have had since your last visit:**

**General: ° fatigue ° chills ° fever ° night sweats ° other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Eyes:** ° **itching** ° **discharge** ° **red eyes** ° **blurry vision** ° **eyelid swelling**

° **other:\_\_\_\_\_\_\_\_\_\_\_\_**

**Ears:** ° **earache** ° **fullness** ° **hearing loss** ° **ringing** ° **other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nose/Sinuses:** ° **runny nose** ° **stuffy nose** ° **sinus pressure** °  **sneezing** ° **loss of smell** ° **nosebleeds**

° **snoring** °  **other: \_\_\_\_\_\_\_\_\_\_\_**

**Throat:** ° **sore throat** ° **drainage** ° **throat clearing** ° **other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Respiratory:** ° **cough** ° **short of breath** ° **wheezing** °  **chest tightness**

**other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GI:** ° **heartburn** ° **trouble swallowing** ° **abdominal pain** ° **diarrhea** ° **nausea/vomiting**

° **other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Infections:** ° **ear** ° **sinus** ° **bronchiolitis** ° **pneumonia** ° **skin** ° **other**

**Skin:** ° **Dry** ° **Itching** ° **rash** ° **hives** ° **eczema** ° **other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Endocrine:** ° **thyroid** ° **weight gain** ° **weight loss** ° **other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Additional comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2. Since your last visit, have you had any surgeries? any new medical diagnoses? Please explain:**

**3. Preferred pharmacy with cross streets: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4. Have you had any change in insurance? Yes No**

**5. Have you had any changes in home address or contact number? Yes No**

**6. Any change to medication allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Please bring your completed form to the front desk and we will call your name shortly. Thank you!***