

# Evaluation – Follow-Up Visit

Name: \_\_\_\_\_ DOB: \_\_\_\_-\_\_\_\_-\_\_\_\_ Date: \_\_\_\_-\_\_\_\_-\_\_\_\_

Name of Spouse/Partner: \_\_\_\_\_ Referred By: \_\_\_\_\_

Primary Physician: \_\_\_\_\_  I do not have a primary physician.

Reason for today's visit: \_\_\_\_\_

**CHECK IF YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS:**

**CONSTITUTIONAL**

- Weight loss/weight gain Amt:
- Fatigue/Weakness
- Fever

**EYES**

- Vision problem

**HENT**

- Ringing in ears
- Hearing problem
- Headaches

**BREAST**

- Breast Lumps
- Breast Pain
- Breast Discharge / leaking Milk

**CARDIOVASCULAR**

- Chest pain
- Rapid Heart Rate
- Swelling in legs

**RESPIRATORY**

- Wheezing
- Shortness of breath
- Coughing up blood
- Cough

**GASTROINTESTINAL**

- Heartburn
- Nausea / Vomiting

- Abdominal pain
- Constipation / Diarrhea
- Bloody stools
- Persistent Bloating

**GYN**

- Not having periods
- Irregular periods
- Heavy periods
- Bleeding between periods
- Painful periods
- Pelvic pain
- Pain with intercourse
- Spotting with or after intercourse
- Decreased sex drive
- Vaginal discharge
- Vaginal dryness
- Hot flashes / night sweats

**URINARY**

- Urinary frequency
- Urinary urgency
- Difficulty starting to urinate
- Painful urination
- Blood in urine
- Leaking urine

**SKIN**

- Rash / itching

- New skin lesions
- Changes in existing lesions/moles

**NEUROLOGIC**

- Seizures
- Dizziness / Fainting/Passing out

**MUSCULOSKELETAL**

- Joint pain / swelling
- Muscle pain / weakness

**ENDOCRINE**

- Excessive urination
- Excessive thirst
- Cold intolerance
- Heat intolerance
- Loss of hair

- Changes in hair texture
- Changes in skin texture
- Excessive hair growth

**PSYCHIATRIC**

- Anxiety / depression
- Difficulty sleeping

**HEMATOLOGIC/BLOOD**

- Anemia
- Easy bleeding / bruising
- Swollen lymph nodes

**ALLERGIC**

- Sinus allergy symptoms

**NEW MEDICAL CONDITIONS SINCE YOUR LAST VISIT?**  No  Yes (If Yes, please list)

**HEALTH SCREENINGS SINCE LAST VISIT (If ordered through another physician's office)  NONE**

**Last Bone Density Test** Year: \_\_\_\_\_  Normal  Abnormal \_\_\_\_\_

**Last Colonoscopy** Year: \_\_\_\_\_  Normal  Abnormal \_\_\_\_\_

**Last Mammogram** Year: \_\_\_\_\_  Normal  Abnormal \_\_\_\_\_

**Last Pap Smear** Year: \_\_\_\_\_  Prior Abnormal Pap Smear Year: \_\_\_\_\_

**SURGERY SINCE YOUR LAST VISIT?**  No  Yes (If Yes, please list)

**NEW MEDICAL PROBLEMS IN YOUR FAMILY SINCE YOUR LAST VISIT?**  No  Yes (If Yes, please list)

**ALLERGIES**

Medication /Food/Environmental Allergies and Reaction: \_\_\_\_\_

**CURRENT MEDICATIONS:** Please list your current medications, even over the counter, vitamins, herbal remedies, etc. Also indicate if you need a refill on any medication.  No New Medications since last visit

Medication	Strength	How Often	Prescribed By	Reason	Refill needed

**IMMUNIZATION HISTORY:** Have you received the following vaccinations since your last visit?

- Hepatitis B      Date \_\_\_\_\_       HPV      Date \_\_\_\_\_
- Influenza      Date \_\_\_\_\_       Varicella(Chicken pox) Date \_\_\_\_\_
- Tetanus/Tdap      Date \_\_\_\_\_       Rubella (Measles)      Date \_\_\_\_\_

**CURRENT GYNECOLOGICAL HISTORY:** (Fill in blanks or check boxes where appropriate)

Days between the first day of each period: \_\_\_\_ days      Duration of flow: \_\_\_\_ days  
 Flow:  Light  Medium  Heavy      Frequency that you change protection \_\_\_\_\_  
 1<sup>st</sup> Day of Last Menstrual Period: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Menopausal      Age at Menopause \_\_\_\_\_       Unexpected bleeding since menopause  
 How do you prevent pregnancy? \_\_\_\_\_

**PREGNANCIES SINCE YOUR LAST VISIT?**  No  Yes (If Yes, please list)

**CURRENT SOCIAL HISTORY:**

Marital Status:  Single  Married  Divorced  Widowed  Steady Relationship  Same -sex partner  
 Are you sexually active?  Yes  No  Plan to be sexually active in future  New partner since last visit  
 Tobacco Use  Never  Current  Former      Amount \_\_\_\_\_ Started \_\_\_\_\_ Stopped \_\_\_\_\_  
 Alcohol Use  Never  Current  Former      Amount \_\_\_\_\_ Started \_\_\_\_\_ Stopped \_\_\_\_\_  
 Recreation Drug Use  Never  Current  Former      Type \_\_\_\_\_ Started \_\_\_\_\_ Stopped \_\_\_\_\_  
 Do you exercise regularly  None  Minimal  Moderate  Heavy  Active but no formal exercise  
 Do you use your seat belt?  Yes  No