FOLLOW-UP MEDICAL & FAMILY HISTORY FORM

NAME: ______________________________________ **TODAY'S DATE:** _______________

DR. BEING SEEN ______________________________ **DATE OF BIRTH:** ________________ **REFERRED BY:** _________________________

REASON FOR VISIT ____ **PRIMARY CARE PHYSICIAN:** _________________________

Allergies

O None O Demerol O IV Contrast or Iodine O Penicillin O Sulfa Other_________________

O Aspirin O Eggs O Latex O Propofol/Diprivan O Versed

Past or Present Medical Problems: ****** ****PLEASE NOTE ONLY CHANGES SINCE LAST VISIT!!!**********

O None	O Colon Cancer	O Gynecological Cancer	O Lupus	O Stroke
O Anemia	O Crohn's Disease	O Heart Disease	O Osteoporosis	O Underactive Thyroid
O Anxiety/Depression	O Diabetes Mellitus	O Hepatitis	O Pancreatitis	O Ulcer
O Arthritis	O Diverticulitis	O High Blood Pressure	O Prostate Cancer	O Ulcerative Colitis
O Asthma	O Diverticulosis	O High Cholesterol	O Prostate Enlargement	O Other _______________
O Atrial Fibrillation	O Emphysema/COPD	O Irritable Bowel Syndrome	O Psychiatric Disease	O Other Cancer _____________
O Barrett's Esophagus	O Esophageal Cancer	O Kidney Disease	O Reflux (GERD)	
O Bleeding Disorder	O Gallstones	O Kidney Stones	O Rheumatoid Arthritis	
O Breast Cancer	O Glaucoma	O Liver Disease	O Seizure Disorder	
O Celiac Sprue	O Gout	O Lung Cancer	O Sleep Apnea	

Surgeries/Hospitalization/Procedures: ********** ***SINCE LAST VISIT ONLY!!!************

O None	O Colon Surgery	O Gallbladder Surgery	O Hernia Surgery	O Prostate Surgery
O Appendectomy	O Colonoscopy	O Gastric Bypass/Obesity Surgery	O Hiatal Hernia Repair	O Tonsillectomy
O Blood Transfusions	O Colostomy	O Gynecologic Surgery	O Joint Replacement	O Upper Endoscopy
O C-Section	O Defibrillator (AICD)	O Heart Stent	O Orthopedic Surgery	O Other______________
O Cataracts	O ERCP	O Heart Surgery	O Pacemaker	

SOCIAL HISTORY - ******* ***PLEASE DESCRIBE BELOW ANY CHANGES SINCE YOUR LAST VISIT HERE*********:

O Marital Status ____ O Alcohol Use ___________________________________

O Employment ____ O Tobacco Use ___________________________________

Review of Systems

Gastrointestinal

- O None
- O Abdominal pain
- O Belching
- O Black Stools
- O Bloating
- O Blood in Stool
- O Change in Bowel Habits
- O Constipation
- O Diarrhea
- O Gas
- O Heartburn
- O Hemorrhoids
- O Incontinence to Stool
- O Irritable Bowel Syndrome
- O Jaundice
- O Loss of Appetite
- O Milk Intolerance
- O Nausea
- O Painful Bowel Movement
- O Vomiting
- O Other_______________

Genitourinary

- O None
- O Blood in Urine
- O Dark Urine
- O Diminished Urine Flow
- O Frequent Urinary Infections
- O Frequent Urination
- O Irregular Menstruation
- O Pain on Urination
- O Sexually Transmitted Disease
- O Urinary Incontinence
- O Other__________________

Skin/Integument

- O None
- O Itching
- O Rash
- O Other_________________

Cardiovascular

- O None
- O Angina/Chest Pressure w/activity
- O Ankle Swelling
- O Irregular Heart Beat
- O Other ____________________

Neurological

- O None
- O Dizziness
- O Headaches
- O Seizures
- O Stroke or Paralysis
- O Other _________________

Endocrine

- O None
- O Cold Intolerance
- O Excessive Thirst
- O Other _____________________

Constitutional

- O None
- O Fever
- O Night Sweats
- O Weight Gain
- O Weight Loss
- O Other ________________

Psychiatric

- O None
- O Abnormal Sleep
- O Chronic Anxiety
- O Depression
- O Memory Loss/Confusion
- O Other _____________________

Eyes

- O None
- O Change in Vision
- O Dry Eyes
- O Eye Pain
- O Other_________________

Hematologic

- O None
- O Enlarged Glands
- O Prolonged Bleeding
- O Other ___________________

Ears, Nose and Throat

- O None
- O Bleeding Gums
- O Chronic Sore Throat
- O Dry Mouth
- O Hoarseness
- O Mouth Sores
- O Nose Bleeds
- O Other ___________________

Musculoskeletal

- O None
- O Back Pain
- O Joint Pain
- O Muscle Pain
- O Other _____________________

Respiratory

- O None
- O Chronic Cough
- O Shortness of Breath
- O Wheezing
- O Other ___________________

Immunologic

- O None
- O Ear Infections
- O Flu
- O Pneumonia
- O Other ____________________

FAMILY HISTORY **SINCE YOUR LAST VISIT TO OUR OFFICE HAS THERE BEEN ANY CHANGE TO IMMEDIATE FAMILY'S HEALTH HISTORY?**

O Parents ____ O Siblings ____________________________________ O Children _______________________________

YOUR PHARMACY

____________________________________	___________________________________	_______________________	________________________
Name	**Location**	**Phone Number**	**Fax Number**

Medication Name	**Dosages/Strength**	**How Often Taken?**