Return Visit Form

Name: _____**Age:**_____**DOB:**_____**Date:**_____
Who would you like to receive your medical note?
Primary Care Physician Name:
Other Physician(s) involved in your care:

Describe the symptom/problem that you want the provider to address with you at this visit:

What has changed since your last visit?:

Change in Pharmacy? _____No _____Yes
Allergies to Medications: _____ **No Known Drug Allergies** (Please include any problems with anesthesia)
Medication Name **Reaction**

Current Medications:
Drug Name/Dosage/Frequency **Drug Name/Dosage/Frequency**

Has any of the following changed since your last visit? (Please c the appropriate answer below)

Tobacco Use: NO YES	Alcohol Use: NO YES
Employment Status: NO YES	Marital Status: NO YES

Review of Systems (Please check any of the following you currently experience)

Constitutional
Appetite Change
Fatigue
Fever
Unexplained weight change

HENT Neck
Pain Neck
Stiffness
Hearing Loss
Tinnitus (ear ringing)
Nosebleeds
Dental Problem
Sore Throat
Trouble Swallowing
Voice Change

EYES
Photophobia (eye pain to light)
Visual Disturbance

Respiratory
Apnea (no breathing)
Chest Tightness
Choking
Cough
Shortness of Breath
Wheezing

Cardiovascular
Chest Pain
Leg Swelling
Palpitations

GI
Abdominal Pain
Constipation
Diarrhea
Nausea
Vomiting

GU
Dysuria (painful urination)
Flank Pain
Frequency
Hematuria
Urgency

MS
Arthralgias (joint pain)
Back Pain
Gait Problem
Joint Swelling
Myalgias (muscle pain)

Skin
Color Change
Rash
Wound

Neurological
Dizziness
Headaches
Lightheadedness
Numbness
Seizures
Speech Difficulty
Syncope (fainting)
Tremors
Weakness

Hematologic
Adenopathy (large lymph nodes)
Bruises/Bleeds Easily

Psychiatric
Agitation
Behavior problem
Confusion
Decreased concentration
Dysphonic mood (unhappiness)
Hallucinations
Hyperactive
Nervous/Anxious
Sleep Disturbance
Suicidal Ideas

Height:_____Weight:_____BP:_____Temp:_____Pulse:_____