Follow Up Visit

Patient Name: _____ Date of Appointment: ____/____/_____

Have there been any significant changes in your medical, social or surgical, or Allergy history?

Have you stopped or started any new medications since your last visit?

Where is your worst pain?

Does it go down the arm, leg or anywhere else?

PAIN LINE: Draw a perpendicular line or arrow to indicate your usual level of pain

No PAIN Worst possible PAIN

0 10

|_____|

What makes it better? (i.e. sitting, rest, medications, changing position)

What makes it worse? (i.e. standing, walking, certain positions)

Are you having any ***NEW*** weakness, numbness, bowel or bladder problem, falls or other concerning problems?

What pain medications are you currently taking?

Do they help?

What things are you able to do currently that you could not do without the medications?
i.e. heavy chores like vacuuming and cleaning the tubs, standing and walking longer, work, sleep without being woke by pain.

Patient Name: _____ Date of Appointment: ____/____/___

Account #: _____

Review of Systems: Please check [√] any of the following symptoms you are having:

Constitutional	**Cardiovascular**	**Gastrointestinal**
☐ unexplained weight loss/gain	☐ new chest pain/pressure/tightnes	☐ acid reflux
☐ new weakness	☐ irregular heart rate/beat	☐ history of stomach ulcer
☐ fevers/chills/night sweats	☐ trouble breathing while lying	☐ bloody or dark stools
☐ NONE	☐ high blood pressure	☐ constipation
	☐ NONE	☐ nausea/vomiting
		☐ hepatitis A/B/C
		☐ NONE
Integumentary	**Ear/Nose/Throat**	**Musculoskeletal**
☐ new rash	☐ vertigo/dizziness	☐ joint pain / stiffness
☐ frequent bruising	☐ loss of hearing	☐ joint redness and swelling
☐ itching	☐ ringing in the ear	☐ muscle cramps
☐ bleeding	☐ nose bleed	☐ new weakness
☐ nail or hair changes	☐ trouble swallowing	☐ NONE
☐ hives	☐ NONE	
☐ sores that don't heal		
☐ NONE		
Neurological	**Respiratory**	**Genitourinary**
☐ new headache	☐ shortness of breath	☐ blood in the urine
☐ blackouts or fainting	☐ sleep apnea	☐ urgency to urinate
☐ tingling / numbness	☐ cough – new or chronic?	☐ loss of bladder control
☐ paralysis	☐ tuberculosis	☐ frequent urination
☐ seizures	☐ NONE	☐ new difficulty urinating
☐ memory loss		☐ NONE
☐ NONE		
Eyes	**Psychological**	**For Clinical Use only**
☐ blurry vision	☐ depression	
☐ double vision	☐ anxiety	**Ht.** _____ **Wt.** _____
☐ cataracts	☐ thoughts of suicide, hurting yourself or anyone else	**B/P** _____ **P** _____
☐ glaucoma	☐ trouble falling asleep	
☐ eye pain	☐ NONE	
☐ NONE		

Do you want me to arrange special treatment or counseling, for depression, anxiety, or if you are having any thoughts of hurting yourself or anyone else? Yes No NA

Have you ever had any problems with drug (including prescription) or alcohol abuse or misuse (including DUI or any drug or alcohol related charges or convictions)?

Findings were reviewed and confirmed with the patient

_____

Daniel S. Heller, MD