

Returning Patient Questionnaire

Please do your best to answer completely.

Your name: _____

Has your **phone number** changed? () -

Date _____

Has your **primary doctor** changed?

Has your **pharmacy** changed?

Name: _____

Address: _____

City, ST ZIP: _____

Phone #: _____

Fax #: _____

Name: _____

Address: _____

City, ST ZIP: _____

Phone #: _____

Fax #: _____

Are you taking any new medications since your last visit? (attach extra page if needed)

name	dose	frequency	reason	since	name	dose	frequency	reason	since

What brings you to the doctor today?

- Regularly scheduled follow-up for same thing as last time
- Regularly scheduled follow-up, new problem
- Follow-up visit after doctor saw me in the hospital
- Go over test results
- Returning sooner than planned
- Haven't been here in a while
- Urgent problem that developed very recently

Describe new problem (if applicable) in 10 words or less:

Misc Personal Information:

- | No | Yes | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Any recent change in where you live, or whom you live with? |
| <input type="checkbox"/> | <input type="checkbox"/> | Any recent change in your work duties (retirement, new job, disability, etc)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Any recent change in how much you smoke or drink? |

Update on other medical problems:

- | No | Yes | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you spent any nights in a hospital since your last visit? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been to the ER since your last visit? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you seen your primary doctor since your last visit? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did any of your doctors change any of your medications since your last visit? |

Review of Systems:

Please check all applicable.

Constitutional

- | No | Yes | |
|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | fevers |
| <input type="checkbox"/> | <input type="checkbox"/> | weight change (loss or gain) |
| <input type="checkbox"/> | <input type="checkbox"/> | change in your appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble <i>getting</i> to sleep |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble <i>staying</i> asleep |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleepiness during the day time |
| <input type="checkbox"/> | <input type="checkbox"/> | |

Eyes, Ears, Nose, Mouth, Throat

- | No | Yes | |
|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | changes in your vision |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> | |

Cardiovascular and Respiratory

- | No | Yes | |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> | shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | |

Gastrointestinal

- | No | Yes | |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea or vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> | diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | |

Bladder function

- | No | Yes | |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | urgency to urinate |
| <input type="checkbox"/> | <input type="checkbox"/> | loss of bladder control |
| <input type="checkbox"/> | <input type="checkbox"/> | |

Neurological

- | No | Yes | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Lost consciousness, fainted, passed out |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness or tingling |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness or lightheadedness |
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness |
| <input type="checkbox"/> | <input type="checkbox"/> | Shaking or involuntary movements |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble walking |
| <input type="checkbox"/> | <input type="checkbox"/> | Falling |
| <input type="checkbox"/> | <input type="checkbox"/> | |

Musculoskeletal

- | No | Yes | |
|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | pain in back or neck |
| <input type="checkbox"/> | <input type="checkbox"/> | joint pain or swelling |
| <input type="checkbox"/> | <input type="checkbox"/> | muscle pain or cramps |
| <input type="checkbox"/> | <input type="checkbox"/> | |

Memory, Thinking, Mood, Psychiatric

- | No | Yes | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Memory loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Seeing or hearing things (hallucinations) |
| <input type="checkbox"/> | <input type="checkbox"/> | Depressed mood |
| <input type="checkbox"/> | <input type="checkbox"/> | Low energy |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> | |

Other

- | No | Yes | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | |
| <input type="checkbox"/> | <input type="checkbox"/> | |