PATIENT FOLLOW UP FORM: Name: _____ Date: _____

Please answer the following questions as you experienced since your last visit. Please us the following rating.

SYMPTOM QUESTIONNAIRE

0 = NO difficulty
1 = a LITTLE bit of difficulty
2 = MODERATE difficulty
3 = QUITE a BIT of difficulty
4 = EXTREME difficulty

Females Only: Are you pregnant/or think you may be pregnant? Yes | No

List any form of birth control you are taking:

_____

	1.	Manage day-to-day life. (Getting places on time, handling money, making decisions)
	2.	Household responsibility. (Shopping, cooking, laundry, cleaning)
	3.	Work. (Click completing tasks, performance, completing assignments, attendance)
	4.	School. (Academic performance, completing assignments, attendance)
	5.	Leisure time or recreational activities.
	6.	Adjusting to major life stresses. (Separation, job, divorce, new job, a death, moving)
	7.	Relationships with family members.
	8.	Getting along with others outside of your family.
	9.	Isolation or feelings of loneliness.
	10.	Being able to feel close to others.
	11.	Developing independence.
	12.	Goals or direction in life.
	13.	Lack of self-confidence, feeling bad about yourself.
	14.	Apathy, lack of interest in things.
	15.	Depression, hopelessness.
	16.	Suicidal thoughts or behavior.
	17.	Homicidal thoughts or behavior.
	18.	Physical symptoms. (Headaches, pains, sleep, appetite)
	19.	Fear, anxiety, panic.
	20.	Confusion, concentration, memory.
	21.	Disturbing thoughts or beliefs.
	22.	Manic or bizarre behavior.
	23.	Mood swings, unstable moods.
	24.	Uncontrollable compulsive behavior.
	25.	Drinking alcohol or illegal drug use.
	26.	Controlling temper, outbursts of anger, violence.
	27.	Impulsive, illegal, or reckless behavior.
	28.	Feeling satisfaction in your life.
	29.	Sexual activities or preoccupation.
	30.	Hearing voices, seeing things.
	31.	Being realistic about yourself and others.
	32.	Recognizing and expressing emotions appropriately.

MEDICATION RECONCILIATION: Please list **all current medications** that you are taking **including** medications prescribed by **different providers**.

1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	

REVIEW OF SYSTEMS: Please review the symptoms below for each organ system. **Circle** all that apply since your last visit. If none apply, **circle** NONE for each section.

CONSTITUTIONAL: Low energy, easily fatigued, difficulty sleeping, appetite increased/decreased, weight gain/loss, hot flashes, cold spells, excessive sweating. NONE

EYES: Blurred vision, double vision, decreased acuity, red, swollen, itchy. NONE

EENT: Headache, dizziness, ringing in ears, hoarseness, difficulty swallowing. NONE

HEART: Pain, rapid heartbeat, irregular heartbeat, shortness of breath, any swelling of hands/feet. NONE

LUNGS: Wheezing, difficulty breathing, dry cough, productive cough. NONE

GI: Abdominal pain, heartburn, constipation, diarrhea, nausea, vomiting, vomiting blood, black/tarry stools, bright red blood in stools. NONE

URINARY: Urgency, frequency, decreased urination, pain with urination, blood in urine, kidney stones, bladder infection, erectile dysfunction, anorgasmia. NONE

SKIN: Bruising, skin tears, rash, itching, skin breakdown. NONE

MUSCULOSKELETAL: Muscle pain, joint pain, weakness, limited mobility. NONE

NEUROLOGICAL: Tremor, rigidity, slow movement, paralysis, seizures, loss of balance. NONE

PAST FAMILY/SOCIAL HISTORY: Since your last office visit have there been any changes in your:
Job: (Yes | No) *Family Relations:* (Yes | No) *Activities of Daily Living:* (Yes | No)

Height: _____ Weight: _____

OFFICE USE ONLY: BMI: _____
BP: ___/___ P: _____ R: _____

PLEASE FILL OUT ALL SECTIONS LISTED ON THE FOLLOW UP FORM, AS THIS IS REQUIRED DOCUMENTATION