FOLLOW UP 12/15

Patient name	Date of birth	Preferred Pharmacy
Reason for today's visit:		

Last Flu Shot	Pneumonia	Tdap	Eye Exam	Colonoscopy	Mammogram	Pap Smear	Bone Density

AName of Medication *Example: Ibuprofen*	**Strength** *200mg*	**No. per day** *2 twice daily*	**Refill needed?**

During the *past 2 weeks*, have you had any of the following symptoms? *(Mark all that apply.)*

GENERAL
____Fevers / chills
____Sweats
____Unexplained weight loss or gain
____Weakness or fatigue

HEENT
____Change in vision
____Eye pain
____Difficulty hearing
____Ringing in ears
____Problem with teeth / gums
____Hay fever / allergies
____Sore throat

CARDIOVASCULAR
____Chest pain
____Heart racing or skipping
____Swelling

RESPIRATORY
____Cough
____Wheezing
____Difficulty breathing

BREASTS
____Lump, tenderness in breast
____Discharge from nipple

GASTROINTESTINAL
____Abdominal Pain
____Nausea or vomiting
____Heartburn
____Difficulty or pain with swallowing
____Diarrhea
____Constipation
____Blood in bowel movement

GENITAL / URINARY
____Urinating more than twice during night
____Leaking urine
____Difficulty emptying bladder
____Blood in urine
____Unusual vaginal bleeding
____Difficulty with sexual function
____Discharge from penis or vagina

MUSCLES / JOINTS
____Muscle pain or cramps
____Joint pains
____Neck or back pain

SKIN
____Rashes or skin lesions
____Changed or worrisome moles

NEUROLOGICAL
____Headaches
____Dizziness / lightheaded
____Weakness of face, arm, or leg
____Numbness or tingling
____Memory loss
____Problems with balance or coordination

PSYCHIATRIC
____Anxiety / stress
____Depression or feeling down
____Problems with sleep

BLOOD /LYMPHATIC
____Unexplained bruises
____Unexpected / easy bleeding

ENDOCRINE
____Excessive thirst or urination
____Hot flashes or night sweats
____Intolerance to heat or cold

Females <55 years: What was the first day of your last menstrual period? _____

What do you do to prevent pregnancy? _____

Recent Surgeries/Hospitalizations

(Or Circle) **No Change**

Any New Family Illnesses/Deaths

(Or Circle) **No Change**

Tobacco Use: θ Yes θ No
Alcohol Use: θ Yes θ No
Caffeine Intake: θ Yes θ No
Exercise: θ Yes θ No
Marital Status:

_____
Patient Signature

******FOR YOUR SAFETY, WE DO NOT ACCEPT REFILL REQUEST FROM PHARMACIES. REFILLS MUST BE REQUESTED BY THE PATIENT.******