

RETURN VISIT

Chart#

Date: _____

Name: _____ Age: _____ Date of Birth _____

Marital Status: _____ Occupation: _____

REASON FOR VISIT (please circle): Annual Visit Problem (Description) _____

Referred by: _____ Primary Care Doctor: _____

CURRENT MEDICATIONS

Drug Name	Dosage	Prescribed by	Drug Name	Dosage	Prescribed by
ALLERGIES TO MEDICATIONS/SUBSTANCES			LIST: _____		
List all natural or herbal remedies, over the counter drugs, vitamins, minerals you are taking			LIST: _____		

PAST MEDICAL /FAMILY HISTORY UPDATE

CHANGES? YES _____ **List:** _____ **Tobacco Use** yes no
NO _____ **Alcohol Use** yes no
Family History of blood clots yes no
Contraceptive choice? N/A _____

SURGERY/HOSPITALIZATIONS UPDATE

No changes _____

Procedure	Date	Procedure	Date	Procedure	Date

GYNECOLGIC UPDATE

Date of Last menses?	How many days between menses?	Do you pass clots? Yes No
How many days does menses last?	Flow: Light Medium Heavy	Bleeding between menses? Yes No

REVIEW OF SYMPTOMS (Please mark all that apply)

Symptoms	Yes	Symptoms	Yes	Symptoms	Yes
<i>Constitutional</i>		<i>Respiratory</i>		<i>Musculoskeletal</i>	
Fatigue		Cough		Joint pain	
Fever		Shortness of Breath		Muscle pain	
Weight Loss		Wheezing		Muscle weakness	
Weight Gain		Coughing up Blood			
<i>Other:</i>		<i>Gastrointestinal</i>		<i>Endocrine</i>	
<i>Eyes, Ears, Nose and Throat</i>		Nausea/vomiting		Heat/cold Intolerance	
Impaired Vision		Constipation		Hair loss	
Vision Change		Blood in stool		Hot flashes	
Headache		Diarrhea		Night sweats	
Sore throat		<i>Genitouriney</i>		<i>Psychiatric</i>	
Lightheadedness		Urgency to urinate		Anxiety	
Sinusitis		Frequency of urination		Depression or frequent crying	
Ulcers		Painful urination		Difficulty sleeping	
<i>Breast</i>		Blood in urine		<i>Hematologic</i>	
Lumps		Incomplete emptying of bladder		Easy bruising	
Tenderness		Incontinence		Bleed easily	
Swelling		<i>Skin</i>		Enlarged lymph glands	
Nipple Discharge		Rash		Blood transfusions	
<i>Cardiovascular</i>		Moles (new growth or changes)			
Chest pain		<i>Neurologic</i>			
Irregular heart beat		Numbness			
		Memory Difficulties			
		Seizures			

FORM COMPLETED BY: _____ PATIENT _____ OFFICE NURSE _____ PHYSICIAN _____ OTHER: _____

SIGNATURE OF PATIENT: _____

SIGNATURE OF PHYSICIAN: _____