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RETURN VISIT FORM

DATE OF APPOINTMENT _____

NAME _____ **AGE** _____

REASON(S) FOR FOLLOW-UP APPOINTMENT _____

CURRENT MEDICATIONS (INCLUDE ALL OVER-THE-COUNTER MEDS AND DOSAGES, SUPPLEMENTS, HERBS) _____

ANY RECENT SIGNIFICANT CHANGE IN YOUR MEDICAL HISTORY (IF YES, PLEASE EXPLAIN)? _____

REVIEW OF SYMPTOMS (CIRCLE ALL THAT APPLY TO YOU):

- | | | | |
|-----------------------|-----------------------|------------------------|--|
| ● achy joints | ● palpitations | ● chest pain | ● allergies (itchy, sneezy, runny, and/or stuffy) |
| ● constipation | ● heartburn | ● abdominal pain | ● difficulty with swallowing |
| ● diarrhea | ● nausea | ● vomiting | ● unexpected significant weight gain/loss |
| ● loss of appetite | ● night sweats | ● hemorrhoids | ● need to urinate during sleep _____ # times/night |
| ● shortness of breath | ● persistent fatigue | ● insomnia/poor sleep | ● poor exercise tolerance |
| ● low sex drive | ● blood in stools | ● blood in urine | ● frequent urinary tract infections |
| ● low back pain | ● painful urination | ● urinary incontinence | ● difficulty with erections |
| ● neck pain | ● headaches/migraines | ● skin/nail problems | ● cold hands and/or feet |
| ● dizziness | ● memory loss | ● hearing loss | ● vaginal itching/discharge |
| ● dry eyes | ● restless legs | ● anxiety/depression | ● recurrent yeast infections |
| ● swollen glands | ● varicose veins | ● hot flashes | ● bleeding between menstrual cycles |
| ● dry skin | ● hair loss | ● pain with sex | ● bleeding with sex |
| ● lumpy breasts | ● nipple discharge | ● acne | ● pelvic pain (not necessarily with sex) |
- other(s)--please explain _____

EXAMINATION (or unchanged from last visit dated _____)

- | | | | |
|----------------------------|------------------------------|--------------------------------|----------------|
| ● Blood pressure _____ | ● weight _____ | ● pulse _____ | ● height _____ |
| ● HEENT--normal or _____ | ● Neck--normal or _____ | ● Lungs--normal or _____ | |
| ● Thyroid--normal or _____ | ● Abdominal--normal or _____ | ● Extremities--normal or _____ | |
| ● CV--normal or _____ | | | |
| ● Breasts--normal or _____ | | | |
| ● Other _____ | | | |

LABS/TEST RESULTS _____

ASSESSMENT/PLAN (USE BACKSIDE FOR ADDITIONAL INFORMATION):