YUN-CHING CHEN, M.D.
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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_____
●Thyroid--normal or _____ ●Lungs--normal or_____
●CV--normal or_____ ●Abdominal--normal or_____
●Breasts--normal or_____ ●Extremities--normal or_____
●Other_____

LABS/TEST RESULTS _____

ASSESSMENT/PLAN (USE BACKSIDE FOR ADDITIONAL INFORMATION):