Follow Up Visit Questionnaire

Please provide as much detail as possible

Patient Name:____Date of Service:____________

Name of your Current Family Physician_________________________________

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Reason for your Follow up visit:____

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Medications

Please list your updated medications and doses since your last visit. If you brought your medication list, attach to this questionnaire:

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Allergies

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Immunizations

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Hospital visits/Surgeries

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MacEwan MEDICAL CLINIC

Please circle the symptom or symptoms that you currently have or have had in the last six months. If you don't have any symptoms, please circle no symptoms.

General:
Fever
Chills
Weight loss
Weight gain
Fatigue
Syncope
Excessive sweating
Depression
Anxiety
No Symptoms

Eyes/Ears:
Change in vision
Blurred vision
Double vision
Loss of hearing
Ringing of the ears
Earaches
No Symptoms

Throat/Sinus:
Difficulty swallowing
Sore throat
Nasal pain
Nose bleeds
No Symptoms

Neck:
Neck stiffness
Swollen lymph nodes
No Symptoms

Pulmonary:
Shortness of breath
Dry cough
Productive cough
Pneumonia
No Symptoms

Cardiac:
Chest pain
Palpitations
Hypertensions
Heart murmur
No Symptoms

Vascular/Hematologic:
Swollen legs
Blood clots
Anemia
Easy bruising or bleeding
Transfusions
No Symptoms

GI:
Stomach pain
Constipation
Diarrhea
Hepatitis
No Symptoms

Urinary:
Frequency
Incontinence
Infections
No Symptoms

Musculoskeletal:
Muscle aches
Joint pain
No Symptoms

Neurological:
Headache
Seizure
Stroke
Weakness
Tremor
Imbalance
Falls
No Symptoms

Other:
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