

# ESTABLISHED PATIENT FOLLOW UP Todays DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## **PATIENT INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Name** |  | **Date of Birth** |  |
| **Phone Number** |  | **Phone Number** |  |
| **Reason for** **visit** |  | **Pharmacy Name & Number** |  |

## **Any new or Changed Medications (Bring Updated List to Each Visit)**

|  |  |  |
| --- | --- | --- |
|  **Medication name and strength and how often taken** |  **Who Prescribes** |  **Is this new** |
|  |  |  |
|  |  |  |
|  |  |  |

## **Health History**

|  |  |  |
| --- | --- | --- |
| **Diagnosis (circle diagnoses that apply)** | **Diagnosis Date** | **Treating Physician** |
| **Heart Disease:** TIA, heart attack, heart failure, high blood pressure, high cholesterol |  |  |
| **Respiratory Disease:** asthma, bronchitis, pneumonia, COPD |  |  |
| **Musculoskeletal:** arthritis, gout, fractures,  |  |  |
| **Neurologic:** seizures, headaches, head injury |  |  |
| **Autoimmune:** diabetes, lupus, Sjogren’s, Raynaud’s |  |  |
| **Other:** |  |  |

## **Sleep Hygiene Eating**

|  |  |
| --- | --- |
|  How many hours do you sleep at night? |  Weight loss or weight gain? |
|  Do you have nightmares? |  Changes in appetite? |
|  Do you wake up at night? |  Changes in taste of food? |
|  Can you go back to sleep? |  How much water do your drink a day? |