

Established Patient (Follow-up)

Name _____ Date _____

****Please write the main reason or problem for today's visit**

Do not write inside box below

Severity- mild/mod/severe	Duration ___ days/weeks/months/years
Associated sx's _____	
Timing _____	Location _____
Quality _____	Context _____

Please circle if you presently have the following symptoms or conditions:

General- fever / chill/ headaches

Eyes- blurred vision / glaucoma

Ears- hearing loss / tinnitus (noise in the ears) / dizziness / vertigo / ear pain/ ear drainage

Nose- bleeding / difficulty breathing / stuffiness / post nasal drip/ allergies (hay fever) / snoring/ sleep apnea

Throat – soreness / pain or difficulty swallowing / voice changes/ hoarseness / bad taste / bad breath / throat clearing

Neck – lump / thyroid nodules / pain / swollen glands

Respiratory – short of breath / cough / wheezing / asthma

G I. – reflux / heartburn / nausea / ulcers / vomiting / diarrhea

Endocrine – diabetes / weight loss or gain / fatigue / pregnant

Neuro/Psych – stroke / weakness / anxiety / depression

Any other symptoms or problems today?

**** Please write down any changes in your medical history since your last visit (ie: new medications surgery etc.)**

REVIEWED BY CLINICIAN _____