Pharmacy: ___________________________________

SUBSEQUENT VISIT FORM

Date: ____ /_____ /_____ MR#: ________________________

Patient's Name: ______________________________________ Date of Birth: ____/____/____

History of Present Illness

• Reason for visit today: □ follow up only.
□ follow up and I want to discuss: ____

• When did your symptoms first start:
____

• What makes your symptoms better:
____

• What makes them worse:
____

REVIEW OF SYSTEMS: Please check (√) if you are experiencing any of these symptoms.

System	Symptoms
General	___Fever ___Sweats/chills ___Weakness ___Weight change ___Fatigue ___Irritability
Skin	___Color changes ___Skin eruptions ___Itching ___Scaling ___Easy bruising
Eyes	___Redness ___Excessive tearing ___Discharge ___Sensitivity to light ___Visual changes
Ears	___Pain ___Deafness ___Ringing in ears ___Vertigo ___Itching ___Discharge
Nose	___Frequent colds ___Sinus infections ___Frequent nosebleeds ___Snoring
Mouth/throat	___Dental problems ___Jaw pain or clicking ___Postnasal drainage ___Dry mouth ___Sore throat ___Hoarseness ___Frequent throat clearing
Respiratory	___Persistent cough ___Sputum/phlegm ___Wheezing ___Coughing up blood ___Pain on breathing ___Shortness of breath ___Difficulty breathing while lying flat
Cardiovascular	___Chest discomfort ___Swelling of ankles ___Palpitations ___Lightheadedness ___Blood clots ___ fainting
Gastrointestinal	___Heart burn ___Abdominal pain ___Constipation ___Bloody or black stools ___Jaundice ___Difficulty swallowing ___Nausea/vomiting/diarrhea
Genitourinary	___Difficulty urinating ___Painful urination ___ Frequent urination ___ Sexual problems ___Kidney stones <u>WOMEN:</u> date of last menstrual period__________
Endocrine	___Thyroid disorder ___Goiter ___Feel hot or cold when others are not affected
Neurologic	___Frequent headaches ___Dizziness ___Numbness ___ Muscle weakness ___Forgetfulness
Musculoskeletal	___Limited movement of joints ___Swelling of joints ___Painful Joints ___Back or neck pain
Psychiatric	___ Anxiety ___ Depression ___ Hallucinations
Sleep	___ Snoring ___ I have been told that I quit breathing ___ Choking/ gasping for air at night ___ Restless legs ____ Excessive Sleepiness ____ Nightmares

Patient's Name: ____ Date of Birth: ____/____/____ MR#: _________

MEDICATIONS

☐ No changes or new medications since my last visit.

☐ There are changes to my medications since my last visit. *Please inform staff of changes.*

ALLERGIES List any NEW allergies ☐ *No changes to allergies.*

1.______________________________ ____

2.______________________________ ____

CHRONIC MEDICAL CONDITIONS List any *newly* diagnosed medical illnesses: ☐ *No new diagnoses.*

1. ____

2. ____

3. ____

HOSPITALIZATIONS ☐ *No new hospitalizations.*

List any hospitalizations that have not been previously documented.

Hospital & City	Reason	Physician	Date
1.			
2.			
3.			

PREVENTATIVE CARE ☐ *No changes to preventative care.*

Have you received a flu shot this year? ☐Yes ☐No

Have you received a pneumonia (Pneumovax) vaccine? ☐Yes ☐No Year received: _______

TB Skin Test? ☐Yes ☐No Results? ☐Positive ☐Negative Chest X-ray done? ☐Yes or ☐No

SOCIAL HISTORY ☐ *No changes to social history.*

Have you been exposed to asbestos, dust or strong fumes at your work? ☐Yes ☐No

If yes, please describe: ____

Do you keep animals at home? ☐Yes ☐No If so, please describe: ___________________________

Do you smoke now? ☐Yes ☐No

How many packs a day do/did you smoke? ___________________________

Do you drink caffeine? ☐Yes ☐No

If yes: How often and what kind? ____

Do you consume alcoholic beverages? ☐Yes ☐No

If yes: How often and what kind? ____

Do you consider yourself an alcoholic? ☐Yes ☐No

Do you use recreational/illicit drugs? ☐No, never ☐Yes, in the past ☐Yes, currently

If yes, Please describe ____