Follow-Up Visit Form
Ian Wattenmaker, M.D.

Name: ______________________________________ Date: ___________

1. Have your symptoms changed since your last visit here? Y N If so, how?

   ____
   ____

2. Has your condition improved, deteriorated or remained the same since your last visit here? (Circle One)

3. Is the pain mild, moderate or severe? (Circle One)

4. List new treatment since your last visit? ______________________________

DO NOT WRITE IN THIS AREA

CC:

ASSOC:

ONSET:

PRIOR:

PATTERN:

QUALITY:

NIGHT: Y N

FEVERS:

CHILLS:

SPHINCTER FXN: NOR ABN

___ **CHECK IF NO CHANGE SINCE YOUR LAST VISIT TO THIS**

Medication (List All Taken)DoseReason for Medication

____
____
____
____

Allergies:

OFFICE

___ **CHECK IF NO CHANGE SINCE YOUR LAST VISIT TO THIS OFFICE**

PAST MEDICAL HISTORY

Surgeries/Hospitalizations Year

____

____

____

____

5. Have you ever had problems with anesthesia? Y N If yes, describe ______________________________

___ **CHECK IF NO CHANGE SINCE YOUR LAST VISIT TO THIS OFFICE**

REVIEW OF SYSTEMS

Have you ever had problems with your:

	Circle	Describe All Yes Responses
Eyes	Y N	______________________________
Ears, Nose, Throat	Y N	______________________________
Digestive Problem	Y N	______________________________
Bladder or Prostate Problem	Y N	______________________________
Diabetes	Y N	______________________________
High Blood Pressure	Y N	______________________________
Heart Disease	Y N	______________________________
High Cholesterol	Y N	______________________________
Kidney Disease	Y N	______________________________
Bleeding Problems	Y N	______________________________
Hepatitis or Liver Disease	Y N	______________________________
Depression	Y N	______________________________
Cancer	Y N	______________________________
Arthritis	Y N	______________________________
Lungs or Breathing Problems	Y N	______________________________
Seizures or Neurologic Problems	Y N	______________________________

___ **CHECK IF NO CHANGE SINCE YOUR LAST VISIT TO THIS OFFICE**

FAMILY HISTORY

Significant Family History: ____

____

___ **CHECK IF NO CHANGE SINCE YOUR LAST VISIT TO THIS OFFICE**

SOCIAL HISTORY

__ Employed (Occupation: _____________________________) ___ Student ___ Retired
__ Single __ Married __ Divorced __ Widowed
Children Y N If yes, #___

Exercise __ Daily __ Weekly __ Rarely

What Type of Exercise? ____

History of Substance Abuse? Y N What Type? ___________________

Smoke Currently? Y N If Yes, _____ packs per day for ___ years.

Quit Smoking? __ No __ This Year __>5 years __>10 years

Alcohol Consumption? __ Never __ Daily __1-2 Times Per Week __ Rarely

Patient Signature: _________________________________ **Date:** _______________________

Reviewed By: __________________________________, MD **Date:** _______________________

TO BE COMPLETED BY PHYSICIAN
MUSCULOSKELETAL PHYSICAL EXAMINATION

Name: ______________________________ Date: ____________________

CONSTITUTIONAL: Hgt: _____ Wgt: _____ HR. Appearance: Unhealthy
Healthy
Obese
Distress
Other: ______

CARDIOVASCULAR:

	Nor	Abn					
Swelling___		___	R.UE	L.UE	R.LE	L.LE	
Varicosities	___	___		R.UE	L.UE	R.LE	L.LE
Edema	___	___		R.UE	L.UE	R.LE	L.LE
Tenderness	___	___		R.UE	L.UE	R.LE	L.LE
Temperature	___	___		R.UE	L.UE	R.LE	L.LE
Pulses	___	___		R.DP	R.PT	R. Radial	
				L.DP	L.PT	L. Radial	

LYMPHATICS: Palpation of Lymph Nodes

	Nor		Abn
Supraclavicular	___		___
Neck	___		___
Axiallae ___		___	
Inguinal	___		___

MUSCULOSKELATAL: Gait ___ ___

	Inspect/Palp.		ROM		Stability	Strength		
	Nor	Abn	Nor	Abn	Nor	Abn	Nor	Abn
Upper Ext.	___	___	___	___	___	___	___	___
Lower Ext.	___	___	___	___	___	___	___	___
Head/Neck	___	___	___	___	___	___	___	___
Spine/Ribs/ Pelvis	___	___	___	___	___	___	___	___

NEURO/PSYCH:

Coordination	___	___
Finger/Nose	___	___
Heel/Knee/Shin	___	___
Fine Motor Coordination	___	___

SLR
Hoffman's
Finger Jerks
Adductors
Horner's
Spurlings

PSIS

Sensation:

Upper Ext.	___	___
Lower Ext.	___	___
Head/Neck	___	___

Spine/Rib/Pelvis ___ ___

TO BE COMPLETED BY PHYSICIAN
MUSCULOSKELETAL PHYSICAL EXAMINATION

SKIN:

	Head/Neck		Spine/Ribs/Pelvis		Upper Ext.		Lower Ext.	
	Yes	No	Yes	No	Yes	No	Yes	No
Scars	___	___	___	___	___	___	___	___
Rashes	___	___	___	___	___	___	___	___
Lesions	___	___	___	___	___	___	___	___
Ulcers	___	___	___	___	___	___	___	___
Cafe-au-lait Spots	___	___	___	___	___	___	___	___

AA&Ox3 Y N
Appears
Depressed Y N
Anxious Y N
Agitated Y N

STUDIES:

X-RAYS:

MRI:

MYELOGRAM/CT SCAN:

X-RAYS TAKEN TODAY:

DX:

RX:

____ Date: ________________________
Performed By: