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

Name: _	Date:	DO NOT WRITE IN THIS AREA
1.	Have your symptoms changed since your last visit here? Y N If so, how?	CC:
		ASSOC:
2.	Has your condition improved, deteriorated or remained the same since your last visit here? (Circle One)	ONSET:
3.	Is the pain mild, moderate or severe? (Circle One)	PRIOR:
4.	List new treatment since your last visit?	PATTERN:
		QUALITY:
		NIGHT: Y N
		FEVERS:
		CHILLS:
		SPHINCTER FXN: NOR ABN
	CHECK IF NO CHANGE SINCE YOUR LAST VISIT TO THIS	
Medi	cation (List All Taken)DoseReason for Medication	
Allerg	ies:	

PAST MEDICAL HISTORY

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

OFFICE

CHECK IF NO CHANGE SINCE YOUR LAST VISIT TO THIS OFFICE REVIEW OF SYSTEMS Lave you ever had problems with your: Circle Describe All Yes Responses Lyes Y N Lars, Nose, Throat Y N Ladder or Prostate Problem Y N Liadder or Prostate Problem Y N Liadder or Prostate Problem Y N Ligh Blood Pressure Y N Leart Disease Y N Ligh Cholesterol Y N Lidney Disease Y N Lededing Problems Y N Lededing Problems Y N Lededing Problems Y N Ledenting or Liver Disease Y N Leptatitis or Liver Disease Y N Lancer	Surgeries/HospitalizationsYear			
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REVIEW OF SYSTEMS Gree Describe All Yes Responses Free Describe All Yes Persponses Free Describe All Yes Perspo	5. Have you ever had proble	ems with anest	hesia? Y N If yes, describe	
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 Dighabetes Y N Heart Disease Y N Hepatitis or Liver Disease Y N Hepatitis Or L				
Circle Describe All Yes Responses Eyes Y N Ears, Nose, Throat Y N Diagestive Problem Y N Diabetes Y N High Blood Pressure Y N Heart Disease Y N Heart Disease Y N Bleeding Problems Y N Bleeding Problems Y N Bleeding Problems Y N Cancer Y N Lungs or Breathing Problems Y N Beizures or Neurologic Problems Y N CHECK IF NO CHANGE SINCE YOUR LAST VISIT TO THIS OFFICE	CHECK IF NO CH	HANGE SINC	CE YOUR LAST VISIT TO THIS OFFICE	
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Eyes Y N Ears, Nose, Throat Y N Digestive Problem Y N Bladder or Prostate Problem Y N Heart Disease Y N Bled Disease Y N Bled Disease Y N Bleeding Problems Y N Bleeding Pro	Have you ever had problems with	your:		
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 Beizures or Neurologic Problems Y N Ceizures or Neurologic Problems Y N Ceizures or Neurologic Problems Y N CHECK IF NO CHANGE SINCE YOUR LAST VISIT TO THIS OFFICE		Circle	Describe All Yes Responses	
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Diabetes Y N High Blood Pressure Y N Heart Disease Y N High Cholesterol				
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 Beizures or Neurologic Problems Y N CHECK IF NO CHANGE SINCE YOUR LAST VISIT TO THIS OFFICE	Bladder or Prostate Problem	Y N		
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High Cholesterol Y N	High Blood Pressure	Y N		
Kidney Disease Y N Selecting Problems Y N Seizures or Neurologic P	Heart 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		Y N		
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	Seizures or Neurologic Problems	Y N		
EAMILY HICTORY	CHECK IF NO CH	HANGE SINC	CE YOUR LAST VISIT TO THIS OFFICE	
FAMILY HISTORY			FAMILY HISTORY	
Significant 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	d Widowed		
Children Y N If yes, #			
Exercise Daily Weekly	Rarely		
What Type of Exercise?			
71			
History of Substance Abuse? Y N W	hat 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.		Appear	rance:	Unhea Health Obese Distres Other:	у	
CARDIOVASCULAR:	Swelling Varicosities Edema Tenderness Temperature Pulses	Nor		Abn	R.UE	L.UE R.UE R.UE R.UE R.UE R.DP L.DP	R.LE L.UE L.UE L.UE L.UE R.PT L.PT	L.LE R.LE R.LE R.LE R.LE R. Rad L. Rad		
LYMPHATICS:	Palpation of Lyn Supraclavicular Neck Axiallae Inguinal	nph Nod Nor 		Abn						
MUSCULOSKELATAI	L: Gait									
NEURO/PSYCH:	Upper Ext. Lower Ext. Head/Neck Spine/Ribs/ Pelvis Coordination Finger/Nose Heel/Knee/Shin Fine Motor Coordination	Inspec Nor	t/Palp. Abn		ROM Nor ———————————————————————————————————	Abn	<u>Stabilit</u> Nor 	Streng Abn —— —— ——	th Nor —— ——	Abn
					SLR Hoffma Finger Adduct Horner Spurlin	Jerks ors 's				
PSIS	-									
Sensation:	Upper Ext. Lower Ext. Head/Neck									

Spine/Rib/Pelvis	

TO BE COMPLETED BY PHYSICIANMUSCULOSKELETAL PHYSICAL EXAMINATION

SKIN:			Head/Neck		Spine/Ribs/Pelvis Upper Ext.			Lower Ext.		
	C	Yes	No	Yes	No	Yes	s No	Yes	No	
	Scars Rashes									
	Lesions									
	Ulcers									
	Cafe-au- Spots	-lait								
	Spots									
		AA&C Appear		Y	N					
		Аррса	Depressed	Y	N					
			Anxious	Y	N					
			Agitated Y	N						
STUDIES:										
	X-RAY	S:								
	MRI:									
	MYELO	OGRAN	I/CT SCAN:							
	X-RAY	S TAKI	EN TODAY:							
	71 17711	J 17111	iv robiti.							
DV.										
DX:										
RX:										
						Date				

Performed By: