

# Dr. Singh NSC Cardiology – FOLLOW-UP VISIT PATIENT FORM

(To be completed if you have not been seen in over 3 months or were recently hospitalized)

Name \_\_\_\_\_

DOB \_\_\_\_\_

Email \_\_\_\_\_

Family Dr. \_\_\_\_\_

Any hospitalizations, surgery, or other major illness since last visit?

**No Changes**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Any recent heart tests?  
(Outside our office)

Echo (Cardiac ultrasound)

Stress Test

Nuclear Stress Test

Heart Cath

\_\_\_\_\_

Current Medication List

**No Changes**

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\_\_\_\_\_

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Current Allergy List

**No Changes**

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any specific questions for the doctor on this visit?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Date: \_\_\_\_\_

Signature \_\_\_\_\_

# NSC CARDIOLOGY - REVIEW OF SYSTEMS

(to be filled out if not done in the past 3 months)

NAME \_\_\_\_\_ NO CHANGE SINCE LAST VISIT

PLEASE INDICATE BELOW ONLY IF ARE YOU CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS:

## General, constitutional

Poor general health lately ..... yes  
Recent weight loss ..... yes  
Fever/ chills ..... yes  
Fatigue ..... yes

## Eyes and vision

Eye disease or injury ..... yes  
Wear glasses or contact lenses ..... yes  
Blurred or double vision ..... yes  
Glaucoma ..... yes

## Ears, nose, throat

Hearing loss ..... yes  
Ringing in the ears ..... yes  
Sinus problems ..... yes  
Nose bleeds ..... yes  
Bleeding gums ..... yes  
Sore throat or voice change ..... yes

## Genitourinary

Frequent urination ..... yes  
Burning or painful urination ..... yes  
Blood in urine ..... yes  
Sexual difficulty/pain ..... yes  
Irregular periods (female) ..... yes  
Erectile dysfunction (male) ..... yes

## Respiratory

Frequent coughing ..... yes  
Spitting up blood ..... yes  
Shortness of breath ..... yes  
Asthma or wheezing ..... yes

## Gastrointestinal /Extremities

Loss of appetite ..... yes  
Constipation ..... yes  
Nausea or vomiting ..... yes  
Frequent diarrhea ..... yes  
Blood in stool ..... yes  
Leg cramps/pain ..... yes  
Restless legs ..... yes  
Leg ulcers/redness ..... yes

## Musculoskeletal

Joint pain ..... yes  
Joint stiffness or swelling ..... yes  
Weakness of muscles/joints ..... yes  
Muscle pain or cramps ..... yes  
Back pain ..... yes  
Difficulty in walking ..... yes

## Skin and breasts

Rash or itching ..... yes  
Change in skin color ..... yes  
Varicose veins ..... yes  
Breast pain ..... yes

## Neurological

Frequent or recurrent headaches ..... yes  
Lightheaded or dizzy ..... yes  
Convulsions or tingling sensations ..... yes  
Tremors ..... yes  
Strokes / TIA ..... yes  
Head injury ..... yes

## Psychiatric

Memory loss or confusion ..... yes  
Nervousness/ anxiety ..... yes  
Depression ..... yes  
Sleep problems ..... yes  
Snoring/apnea ..... yes

## Endocrine

Glandular or hormone problem ..... yes  
Thyroid disease ..... yes  
Diabetes ..... yes  
Excessive thirst or urination ..... yes  
Heat or cold intolerance ..... yes

## Hematologic/ Lymphatic

Slow to heal after cuts ..... yes  
Easily bruise or bleed ..... yes  
Anemia ..... yes  
Phlebitis ..... yes  
Transfusion ..... yes  
Swollen glands ..... yes

ANY OTHER PROBLEMS:

Date: \_\_\_\_\_

Signature \_\_\_\_\_