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**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Current Allergy List **□ NO CHANGES**

_____ _____

_____ _____

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** _____