FOLLOW-UP PATIENT FORM- Northside Cardiology

(To be completed by all patients who have not been seen in over 3 months)

Name_____ **DOB**_____

Today's date_____ **Date of last visit** _____

Phone# (home)_____ **(work or cell)**_____

Email Address _____

Referring or primary care physician_____ **phone#**_____

Reason for visit _____

List any hospitalizations, surgery or other major illness since last visit

1._____

2._____

3._____

4._____

Any recent heart tests? ☐**Echo (cardiac ultrasound)** ☐**Stress test** ☐ CT/MRI
☐**Nuclear stress test** ☐**Cath** **Date performed**_____
(Please notify front desk to make sure we have requested copy of these tests)

Current medication	**Dosage**	**Frequency (how often)**

Current allergy list

_____

Do you have any specific questions for your doctor?

_____

_____

_____

Patient Name_____ **Date**_____

Please circle all that apply to you:

CONSTITUTIONAL

Good general health lately	Yes	No
Recent weight change	Yes	No
Fevers/chills	Yes	No

RESPIRATORY

Frequent coughing	Yes	No
Shortness of breath	Yes	No
Asthma or wheezing	Yes	No

EYES

Wear glasses/contact lens	Yes	No
Blurry vision	Yes	No

ENT

Sinus problems	Yes	No
Sore throat or voice change	Yes	No

URINARY

Frequent urination	Yes	No
Burning or painful urination	Yes	No
Blood in urine	Yes	No
Sexual difficulty	Yes	No

SKIN

Rash or itching	Yes	No
Varicose veins	Yes	No

ENDOCRINE

Excessive thirst or urination	Yes	No
Heat or cold intolerance	Yes	No

NEUROLOGICAL

Frequent or recurring headaches	Yes	No
Light headed or dizzy	Yes	No
Numbness or tingling sensations	Yes	No

PSYCHIATRIC

Nervousness/anxiety	Yes	No
Depression	Yes	No

HEMATOLOGICAL/LYMPHATIC

Easily bruise or bleed	Yes	No
Anemia	Yes	No
Swollen glands	Yes	No
Previous blood transfusions	Yes	No

GASTROINTESTINAL

Loss of appetite	Yes	No
Change in bowel movement	Yes	No
Nausea or vomiting	Yes	No
Blood in stool	Yes	No
Stomach pain, indigestion	Yes	No

MUSCULOSKELETAL

Joint pain	Yes	No
Muscle pain or cramps	Yes	No
Back pain	Yes	No

SLEEP

Difficulty sleeping	Yes	No
Excessive snoring	Yes	No
Breathing stops at night	Yes	No
Excessive daytime fatigue	Yes	No

CIRCULATION

Do you have any discomfort or aching in the muscles of your legs, arms, thighs or buttocks when you walk that is relieved by rest?	Yes	No
Do your legs ever feel fatigued or heavy when walking or are active?	Yes	No
Do you ever need to stop and rest when walking or have difficulty keeping up with others?	Yes	No
Do your feet or toes bother you at night?	Yes	No
Do you have any painful sores or ulcers on your legs or feet that aren't healing?	Yes	No
Have you experienced TEMPORARY: Loss of vision in one eye?	Yes	No
Slurred speech?	Yes	No
Weakness or numbness of arm or leg on one side of your body?	Yes	No
Have you had surgery, balloon procedures, or stents to any blood vessels other than your heart? Explain: _____	Yes	No
Have you had blockages in your coronary arteries?	Yes	No