Dr. Ahmad Mur, MD
Dr. Jayshree Bhaskara

Follow Up

Date:__/__/_____ Name:_____ Date of Birth:__/__/_____
Reason for Visit:_____

Since your last visit indicate changes

☐ Marital Status:_____ ☐Phone: Personal (___)-___-____ Business (___)-___-____
☐ Address Change – New Address:_____
☐ Health Insurance: _____
Since your last visit have you seen any other Doctors / Dentists: **Yes / No**
If Yes, describe:_____
Did they order any lab tests: **Yes / No** If yes-List: _____
In your family has there been any major illness / deaths: **Yes / No**

List all **Medications** you take (including those you buy without prescription)

1:_____ 2:_____ 3:_____ 4:_____ 5:_____
6:_____ 7:_____ 8:_____ 9:_____ 10:_____

Allergies:
1:_____ 2:_____ 3:_____ 4:_____

Since your last visit Indicate changes / problems with a ✓

General
☐ Fever
☐ Malaise / Fatigability
☐Night Sweats
☐Weight Loss
☐Weight Gain

Dietary
☐Change in appetite
☐Problems with Solid Food

Musculo-skeletal system
☐Joint Stiffness / pain
☐Joint Swelling
☐Joint Redness

Head-Neck-Eyes-Ears
☐Headache
☐Loss of consciousness
☐Glaucoma
☐Visual problems
☐Hearing Loss
☐Ringing in ears
☐Frequent Colds
☐Nose Bleeds
☐Postnasal discharge

Throat – Mouth
☐Hoarseness
☐Sore throat
☐Bleeding gums
☐Mouth ulcers
☐Tooth problems

Skin
☐Rash
☐Itching

Endocrine
☐Thyroid problems
☐Blood sugar problems

RS / CVS
☐Cough
☐Shortness of breath
☐Wheezing
☐Coughing blood
☐Chest pain
☐High blood pressure (bp)
☐Unable to lay flat
☐Palpitations
☐Leg Swelling

GI
☐Trouble swallowing
☐Heartburn
☐Nausea
☐Vomiting
☐Vomit blood
☐Constipation
☐Hemorrhoids
☐Blood in stool
☐Jaundice
☐Gallstones
☐Polyp
☐Diarrhea

GU
☐Dark Urine
☐Frequent urination
☐Burning with urination
☐Blood in urine
☐Hesitancy
☐Incontinence

CNS
☐Seizures
☐Weakness
☐Coordination problems
☐Abnormalities of sensation
☐Tremors
☐Memory Loss
☐Anxiety
☐Depression
☐Sleep Disturbance
☐Marital / Sexual problems

Females: Irregular or painful Menstrual problems: **Yes / No**

Social History: Do you smoke now or did in the past: **Yes / No** Do you drink alcohol now or did in the past: **Yes / No**

Reviewed with:_____ on:__/__/____ Signature:_____