

Endoscopic Microsurgery Associates

FOLLOW UP VISIT

Name: _____

Today's Date: _____

Reason For Visit / Current Problem: _____

Any family members diagnosed w/polyps, cancer since last visit? Please explain: _____

Surgeries / Procedures undergone since last visit:

Allergies:

Please list any medications (including over the counter) that you have been taking since your last visit:

Medication name	Dosage / strength	How often taken?

PLEASE NOTE ANY SYMPTOMS YOU ARE CURRENTLY EXPERIENCING

Gastrointestinal	
<input type="radio"/> None <input type="radio"/> Abdominal pain <input type="radio"/> Black tarry stools	<input type="radio"/> Bloating/Gas <input type="radio"/> Blood in stool <input type="radio"/> Change in bowel habits <input type="radio"/> Constipation <input type="radio"/> Diarrhea <input type="radio"/> Heartburn / Reflux
<input type="radio"/> Incontinence of stool <input type="radio"/> Loss of appetite <input type="radio"/> Nausea <input type="radio"/> Swallowing difficulty <input type="radio"/> Vomiting <input type="radio"/> Other _____	
Genitourinary	Skin
<input type="radio"/> None <input type="radio"/> Blood in urine <input type="radio"/> Dark urine <input type="radio"/> Enlarged prostate <input type="radio"/> Frequent urinary infections <input type="radio"/> Heavy menstruation	<input type="radio"/> Pain / burning w/urination <input type="radio"/> Pregnancy (current) <input type="radio"/> Sexually transmitted disease <input type="radio"/> Urinary incontinence <input type="radio"/> Other _____
<input type="radio"/> None <input type="radio"/> Rash <input type="radio"/> Itching <input type="radio"/> Jaundice <input type="radio"/> Suspicious lesions <input type="radio"/> Other _____	
Cardiovascular	
<input type="radio"/> None <input type="radio"/> Angina/Chest pain	<input type="radio"/> Heart murmur <input type="radio"/> Irregular heartbeat <input type="radio"/> Ankle swelling <input type="radio"/> Rapid heart rate/palpitations <input type="radio"/> Shortness of breath <input type="radio"/> Other _____
Neurological	Endocrine
<input type="radio"/> None <input type="radio"/> Headaches <input type="radio"/> Memory loss/confusion <input type="radio"/> Numbness/tingling	<input type="radio"/> Seizures <input type="radio"/> Stroke <input type="radio"/> Other _____
<input type="radio"/> None <input type="radio"/> Cold intolerance <input type="radio"/> Excessive thirst <input type="radio"/> Excessive urination <input type="radio"/> Heat intolerance <input type="radio"/> Other _____	
Constitutional	Psychiatric
<input type="radio"/> None <input type="radio"/> Chills <input type="radio"/> Fatigue <input type="radio"/> Fever <input type="radio"/> Loss of appetite	<input type="radio"/> Night sweats <input type="radio"/> Weight gain <input type="radio"/> Weight loss <input type="radio"/> Other _____
<input type="radio"/> None <input type="radio"/> Anxiety <input type="radio"/> Bipolar disorder <input type="radio"/> Depression <input type="radio"/> Other _____	
Eyes	Hematologic
<input type="radio"/> None <input type="radio"/> Double vision <input type="radio"/> Irritation <input type="radio"/> Loss of vision	<input type="radio"/> Pain <input type="radio"/> Redness <input type="radio"/> Other _____
<input type="radio"/> None <input type="radio"/> Anemia <input type="radio"/> Blood transfusions <input type="radio"/> Easy bruising <input type="radio"/> Prolonged bleeding <input type="radio"/> Other _____	
Ears, Nose, Throat	Musculoskeletal
<input type="radio"/> None <input type="radio"/> Sore throat <input type="radio"/> Hoarseness <input type="radio"/> Mouth sores	<input type="radio"/> Nose bleeds <input type="radio"/> Post-nasal drip <input type="radio"/> Recurrent sinus infections <input type="radio"/> Other _____
<input type="radio"/> None <input type="radio"/> Back pain <input type="radio"/> Joint pain <input type="radio"/> Other _____	
Respiratory	Immunologic
<input type="radio"/> None <input type="radio"/> Frequent cough <input type="radio"/> Shortness of breath <input type="radio"/> Snoring	<input type="radio"/> Sleep apnea <input type="radio"/> Wheezing <input type="radio"/> Other _____
<input type="radio"/> None <input type="radio"/> Allergies <input type="radio"/> HIV exposure <input type="radio"/> Immune deficiency <input type="radio"/> Other _____	

Have you had a change in address, phone number, or insurance since your last visit? **YES** **NO**