PATIENT FOLLOW-UP MEDICAL INFORMATION

Welcome back! Please help us to serve you better by completing this form before you see the Doctor.

NAME: _____ **DATE:** _____ **AGE:** _____

Height:_____ **Weight:** _____

REASON YOU ARE SEEING DR. GREENE TODAY? _____

_____

_____

ANY NEW MEDICAL PROBLEMS SINCE YOUR LAST VISIT TO US? ***[ ] Yes*** _____

_____

OR: [ ] No medical problems or treatments since my last visit.

ANY NEW MEDICATIONS SINCE YOUR LAST VISIT? _____

*****LIST ALL YOUR ALLERGIES TO ANY MEDICATIONS:** _____

REVIEW OF SYSTEMS:

General:	**Yes**	**No**
Fever		
Chills		
Headaches		

Ears:	**Yes**	**No**
Hearing Loss-Gradual		
Sudden Hearing Loss		
Ear Pain:		

Face:	**Yes**	**No**
Skin Lesions		
Moles		

GI	**Yes**	**No**
Heartburn		

Nose/Sinus:	**Yes**	**No**
Nose Bleeds		
Injury		
Congestion		
Runny Nose		
Mouth Breathing		

Throat:	**Yes**	**No**
Sore Throat		
Problems Swalling		
Hoarseness		
Sore in Mouth		

Respiratory:	**Yes**	**No**
Cough		
Short of Breath		
Wheezing		
Allergies		