

Texas Digestive Disease Consultants

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 started 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"/> Bloating/Gas | <input type="radio"/> Constipation | <input type="radio"/> Incontinence of stool | <input type="radio"/> Swallowing difficulty |
| <input type="radio"/> Abdominal pain | <input type="radio"/> Blood in stool | <input type="radio"/> Diarrhea | <input type="radio"/> Loss of appetite | <input type="radio"/> Vomiting |
| <input type="radio"/> Black tarry stools | <input type="radio"/> Change in bowel habits | <input type="radio"/> Heartburn / Reflux | <input type="radio"/> Nausea | <input type="radio"/> Other _____ |

Genitourinary

- | | |
|---|--|
| <input type="radio"/> None | <input type="radio"/> Pain / burning w/urination |
| <input type="radio"/> Blood in urine | <input type="radio"/> Pregnancy (current) |
| <input type="radio"/> Dark urine | <input type="radio"/> Sexually transmitted disease |
| <input type="radio"/> Enlarged prostate | <input type="radio"/> Urinary incontinence |
| <input type="radio"/> Frequent urinary infections | <input type="radio"/> Other _____ |
| <input type="radio"/> Heavy menstruation | |

Skin

- | | |
|--------------------------------|--|
| <input type="radio"/> None | <input type="radio"/> Rash |
| <input type="radio"/> Itching | <input type="radio"/> Suspicious lesions |
| <input type="radio"/> Jaundice | <input type="radio"/> Other _____ |

Cardiovascular

- | | | | |
|---|---|---|---|
| <input type="radio"/> None | <input type="radio"/> Heart murmur | <input type="radio"/> Ankles swelling | <input type="radio"/> Shortness of breath |
| <input type="radio"/> Angina/Chest pain | <input type="radio"/> Irregular heartbeat | <input type="radio"/> Rapid heart rate/palpitations | <input type="radio"/> Other _____ |

Neurological

- | | |
|---|-----------------------------------|
| <input type="radio"/> None | <input type="radio"/> Seizures |
| <input type="radio"/> Headaches | <input type="radio"/> Stroke |
| <input type="radio"/> Memory loss/confusion | <input type="radio"/> Other _____ |
| <input type="radio"/> Numbness/tingling | |

Endocrine

- | | |
|--|---|
| <input type="radio"/> None | <input type="radio"/> Excessive urination |
| <input type="radio"/> Cold intolerance | <input type="radio"/> Heat intolerance |
| <input type="radio"/> Excessive thirst | <input type="radio"/> Other _____ |

Constitutional

- | | |
|--|------------------------------------|
| <input type="radio"/> None | <input type="radio"/> Night sweats |
| <input type="radio"/> Chills | <input type="radio"/> Weight gain |
| <input type="radio"/> Fatigue | <input type="radio"/> Weight loss |
| <input type="radio"/> Fever | <input type="radio"/> Other _____ |
| <input type="radio"/> Loss of appetite | |

Psychiatric

- | | |
|--|-----------------------------------|
| <input type="radio"/> None | <input type="radio"/> Depression |
| <input type="radio"/> Anxiety | <input type="radio"/> Other _____ |
| <input type="radio"/> Bipolar disorder | |

Eyes

- | | |
|--------------------------------------|-----------------------------------|
| <input type="radio"/> None | <input type="radio"/> Pain |
| <input type="radio"/> Double vision | <input type="radio"/> Redness |
| <input type="radio"/> Irritation | <input type="radio"/> Other _____ |
| <input type="radio"/> Loss of vision | |

Hematologic

- | | |
|--|--|
| <input type="radio"/> None | <input type="radio"/> Easy bruising |
| <input type="radio"/> Anemia | <input type="radio"/> Prolonged bleeding |
| <input type="radio"/> Blood transfusions | <input type="radio"/> Other _____ |

Ears, Nose, Throat

- | | |
|-----------------------------------|--|
| <input type="radio"/> None | <input type="radio"/> Nose bleeds |
| <input type="radio"/> Sore throat | <input type="radio"/> Post-nasal drip |
| <input type="radio"/> Hoarseness | <input type="radio"/> Recurrent sinus infections |
| <input type="radio"/> Mouth sores | <input type="radio"/> Other _____ |

Musculoskeletal

- | | |
|---------------------------------|-----------------------------------|
| <input type="radio"/> None | <input type="radio"/> Joint pain |
| <input type="radio"/> Back pain | <input type="radio"/> Other _____ |

Respiratory

- | | |
|---|-----------------------------------|
| <input type="radio"/> None | <input type="radio"/> Sleep apnea |
| <input type="radio"/> Frequent cough | <input type="radio"/> Wheezing |
| <input type="radio"/> Shortness of breath | <input type="radio"/> Other _____ |
| <input type="radio"/> Snoring | |

Immunologic

- | | |
|------------------------------------|---|
| <input type="radio"/> None | <input type="radio"/> Immune deficiency |
| <input type="radio"/> Allergies | <input type="radio"/> Other _____ |
| <input type="radio"/> HIV exposure | |

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