Follow-Up Visits DOB: ____________________

Name: ____ Age: ________________ Date: ________________

Did you have any symptoms or physical problems since your last visit? ______________________________________

Are you taking any new medications or herbal preparations? ____

If yes, please list the complete name and dosage: ____

____

Did you exercise? ____________ If yes, how many days? ______________ Total # of minutes: _________________

Have you been having chest pain, shortness of breath, or heart palpitations with physical activity? If so, please describe ____

If you are on a liquid diet, did you eat any regular foods? If yes, what foods: _______________________________

Did you drink an extra 32 ounces of water daily? ____

Have you experience any of these signs or symptoms since taking the medications or diet prescribed?
Please circle all that apply:

Hunger	Vomiting	Nausea	Indigestion	Constipation
Fluid Retention	Diarrhea	Cravings	Numbness	Cold Extremities
Leg Aches	Chest Pain	Tremors	Dizziness	Shortness of Breath
Light Headed	Fainting	Feeling Weak	Headaches	Rapid Heart Beat
Lack of Interest	Moody Feeling	Spacey	Depression	Difficulty Sleeping
Irritable, Anger	Lack of Control	Confused	Cramps, Gas	Rashes

Other: ____

____

Health Care Provider Section: (patients should not complete this next section):

Subjective:

Weight: ____________ Gain/Loss: ___________ BP: ____________ Pulse: ____________ Head ( )nl:____________
Eyes ( )nl: __________ Neck ( )nl: __________ Throat ( ) __________ Lungs ( )nl: ________________________
Heart ( )nl: _________ Abdomen ( )nl: __________ Neuro ( )nl: _________ Extremities ( )nl: ______________
Skin ( )nl: __________ Other: ____

Plan: ____ Diagnosis: ______________________________________

Diet: ____

Exercise: ____ Medications: ____________________________________

Behavior Modification: Module# _________________ given for review

Next follow up visit _________________________________ Signature: ______________________________________

Medical Symptoms Questionnaire

Subject Name ______________________________ Date:____________________

Visit 1 2 3 4 5 6 7
(circle one)

Rate each of the following symptoms based upon your typical health profile for:

☐ Past 30 days ☐ Past 48 hours

Point Scale

0 - *Never or almost never* have the symptoms
1 - Occasionally have it, effect is *not* severe
2 - Occasionally have it, effect *is* severe
3 - Frequently have it, effect is *not* severe
4 - Frequently have it, effect *is* severe

		OFFICE USE ONLY
HEAD	_________ Headaches _________ Faintness _________ Dizziness _________ Insomnia	Total ______________
EYES	_________ Watery or itchy eyes _________ Swollen, reddened or sticky eyelids _________ Bags or dark circles under eyes _________ Blurred or tunnel vision (does not include near or far-sightedness)	Total ______________
EARS	_________ Itchy ears _________ Earaches, ear infections _________ Drainage from ear _________ Ringing in ears, hearing loss	Total ______________
NOSE	_________ Stuffy nose _________ Sinus problems _________ Hay fever _________ Sneezing attacks _________ Excessive mucus formation	Total ______________
MOUTH/ THROAT	_________ Chronic coughing _________ Gagging, frequent need to clear throat _________ Sore throat, hoarseness, loss of voice _________ Swollen or discolored tongue, gums, lips _________ Canker sores	Total ______________
SKIN	_________ Acne _________ Hives, rashes, dry skin _________ Hair loss _________ Flushing, hot flashes _________ Excessive sweating	Total ______________
HEART	_________ Irregular or skipped heartbeat _________ Rapid or pounding heartbeat _________ Chest Pain	OFFICE USE ONLY

		OFFICE USE ONLY
LUNGS	__________ Chest congestion __________ Asthma, bronchitis __________ Shortness of breath __________ Difficulty breathing	Total ________________
DIGESTIVE TRACT	__________ Nausea, vomiting __________ Diarrhea __________ Constipation __________ Bloated feeling __________ Bleching, passing gas __________ Heartburn __________ Intestinal/stomach pain	Total ________________
JOINTS/ MUSCLE	__________ Pain or aches in joints __________ Arthritis __________ Stiffness or limitation of movement __________ Pain or aches in muscles __________ Feeling of weakness or tiredness	Total ________________
WEIGHT	__________ Binge eating/drinking __________ Craving certain foods __________ Excessive weight __________ Compulsive eating __________ Water retention __________ Underweight	Total ________________
ENERGY/ ACTIVITY	__________ Fatigue, sluggishness __________ Apathy, lethargy __________ Hyperactivity __________ Restlessness	Total ________________
MIND	__________ Poor Memory __________ Confusion, poor comprehension __________ Poor concentration __________ Poor physical coordination __________ Difficulty in making decisions __________ Stuttering or stammering __________ Slurred speech __________ Learning disabilities	Total ________________
EMOTIONS	__________ Moods swings __________ Anxiety, fear, nervousness __________ Anger, irritability, aggressiveness __________Depression	Total ________________
OTHER	__________ Frequent illness __________ Frequent or urgent urination __________ Genital itch or discharge	Total ________________
		OFFICE USE ONLY