

## FOLLOW UP VISIT HISTORY FORM

### PATIENT INFORMATION

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

### ALLERGIES

- No known allergies     No known drug allergies     Other Allergies  
 Codeine     IV Contrast     Latex     Penicillin \_\_\_\_\_

### IMMUNIZATIONS

- None  
 Flu Vaccine     Hep A     Hep B     Pnuemococcal     Other \_\_\_\_\_

### SOCIAL HISTORY

- TOBACCO**     Current everyday     Current some days     Former smoker     Never smoked  
 Current status unknown     Unknown

### ARE YOU CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS?

#### GASTROINTESTINAL

- | <input type="checkbox"/> NONE | YES                      | NO                       |
|-------------------------------|--------------------------|--------------------------|
| Abdominal pain                | <input type="checkbox"/> | <input type="checkbox"/> |
| Belching                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Black stool                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Bloating                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood in stool                | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in bowel habits        | <input type="checkbox"/> | <input type="checkbox"/> |
| Constipation                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Diarrhea                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Gas                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Heartburn                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Jaundice                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of appetite              | <input type="checkbox"/> | <input type="checkbox"/> |
| Milk/lactose intolerance      | <input type="checkbox"/> | <input type="checkbox"/> |
| Nausea                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain with Bowel Movement      | <input type="checkbox"/> | <input type="checkbox"/> |
| Rectal bleeding               | <input type="checkbox"/> | <input type="checkbox"/> |
| Rectal pain                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Stool incontinence            | <input type="checkbox"/> | <input type="checkbox"/> |
| Trouble swallowing            | <input type="checkbox"/> | <input type="checkbox"/> |
| Vomiting                      | <input type="checkbox"/> | <input type="checkbox"/> |

Are you experiencing any other symptoms?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list your preferred pharmacy and address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_