Patient Follow Up Form

Please answer the following questions.

Date: _____ Insurance#: _____

Name:_ _____ DOB: _____ Address: _____

Phone #: _____ Email:_____

Do you have any specific questions for the doctor today? ☐ Yes ☐ No _____
Please List Presenting Concerns/Reason for visit and/or Any changes to your medical history that we should be made aware of? (surgeries, stents, newly diagnosed conditions, etc?)

Please List Current Peer Support Specialist name & Contact: _____

Please List Current Therapist name & contact: _____

Please List Current SUD Counselor name & contact: _____

Please List Pharmacy_____Phone # _____

When was your last visit here? _____

Any hospitalizations, surgery or other major illness since last visit? ☐ Yes ☐ No _____
Any recent heart tests? Echo(cardiac ultrasound) ☐ Yes ☐ No _____
Any recent Stress test Nuclear stress test Heart Cath Other: ☐ Yes ☐ No _____
Have you ever attempted to harm/kill yourself or anyone else? If so, please list the occurrences below
☐ Yes ☐ No _____
Allergies?: _____
Are you currently prescribed ANY medications? ☐ Yes ☐ No :

Name of Medication	Dosage(Mg)	How many times a day?	On this for how long?	Side effects (if any)	Prescribing physician

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Social Determinant of Health Criteria	N/A	Currently Today	In the last 1 month	In the last 3 months	In the last 6 months	In the last 9 months	In the last 12 months
The food bought did not last and there's no money to get more?	☐	☐	☐	☐	☐	☐	☐
Worried about losing housing	☐	☐	☐	☐	☐	☐	☐
Homeless	☐	☐	☐	☐	☐	☐	☐
Unable to get utilities (heat, water, lights)	☐	☐	☐	☐	☐	☐	☐
lack of transportation kept you from medical appointments, non-medical meetings or appts.	☐	☐	☐	☐	☐	☐	☐
feel physically and emotionally safe where you currently live?	☐	☐	☐	☐	☐	☐	☐
been hit, slapped, kicked or otherwise physically hurt by someone?	☐	☐	☐	☐	☐	☐	☐
Been humiliated/emotionally abused in other ways by partner or ex-partner	☐	☐	☐	☐	☐	☐	☐
unable to get utilities (heat, electricity, water)	☐	☐	☐	☐	☐	☐	☐

Nutrition Screening: Score 12-14 points Normal nutritional status, 8-11 points At risk of malnutrition, 0-7 points Malnourished
No PCP listed = Referral to Primary care Physician

1. Has food intake declined over the past three months due to loss of appetite, digestive problems, chewing or swallowing?
0 = Severe food intake decrease ☐ 1 = Moderate food intake decrease ☐ 2 = No food intake decrease ☐

2. Involuntary weight loss during the last 3 months?
0 = Weight loss greater than 6lbs ☐ 1 = Don't know ☐ 2 = Weight loss 2.2-6.6lbs. ☐ 3 = No weight loss ☐

3.Mobility?
0 = Bed or chair bound ☐ 1 = Able to get out of bed/chair, but does not go out ☐ 2 = Goes out ☐

4. Has the patient suffered psychological stress or acute disease in the past three months ☐ 0 = Yes ☐ 2 = No

5. Neuropsychological problems?
0 = Severe dementia or depression ☐ 1 = Mild dementia ☐ 2 = No psychological problems ☐

6.Body mass index (BMI)? _____(weight in kg / height in m2)
0 = BMI less than 19 ☐ 1 = BMI 19 to less than 21 ☐ 2 = BMI 21 to less than 23 ☐ 3 = BMI 23 or greater ☐

7.Calf circumference (CC) in cm ? ☐ 0 = CC less than 31 ☐ 3 = CC 31 or greater

TOTAL SCORE:

PAIN SCREEN: Score 0 Relaxed and comfortable **1–3** Mild discomfort **4–6** Moderate pain **7–10** Severe discomfort or pain or both

CATEGORIES	SCORE 0	SCORE 1	SCORE 2
Face	☐No particular expression or smile	☐ Occasional grimace or frown; Frequent to constant frown, clenched jaw, withdrawn, disinterested	☐Frequent to constant frown, clenched jaw, withdrawn, disinterested quivering chin
Legs	☐Normal position or relaxed	☐Uneasy, restless, tense	☐Kicking or legs drawn up
Activity	☐Lying quietly, normal position, moves easily	☐Squirming, shifting back and forth, tense	☐Arched, rigid, or jerking
Cry	☐No cry (awake or asleep)	☐Moans or whimpers, occasional complaint	☐Crying steadily, screams or sobs; Frequent Complaints
Consolability	☐Content, relaxed	☐Reassured by occasional touching, hugging, Difficult to console or comfort/ being talked to; distractible	☐Difficult to console or comfort
TOTAL SCORE:			

Consumer Name: D.O.B.: Insurance#:

Patient Follow Up Form

Please check yes or no below to indicate if you currently are experiencing any of these symptoms:

General, constitutional

Good general health lately.....☐no ☐yes
Recent weight change..... ☐no ☐yes
Fever/chills.....☐no ☐yes
Fatigue.....☐no ☐yes

Musculoskeletal

Joint pain..... ☐no ☐yes
Joint stiffness or swelling..... ☐no ☐yes
Weakness of muscles/joints..... ☐no ☐yes
Muscle pain or cramps..... ☐no ☐yes
Back pain..... ☐no ☐yes
Difficulty in walking..... ☐no ☐yes

Eyes and vision

Eye disease or injury..... ☐no ☐yes
Wear glasses or contact lenses..... ☐no ☐yes
Blurred or double vision..... . ☐no ☐yes
Glaucoma..... ☐no ☐yes

Skin and breasts

Rash or itching..... ☐no ☐yes
Change in skin color..... ☐no ☐yes
Varicose veins..... ☐no ☐yes
Breast pain..... ☐no ☐yes

Ears, nose, throat

Hearing loss..... ☐no ☐yes
Ringing in the ears.....☐no ☐yes
Sinus problems.....☐no ☐yes
Nose bleeds.....☐no ☐yes
Bleeding gums.....☐no ☐yes
Sore throat or voice change.....☐no ☐yes

Neurological

Frequent or recurrent headaches....☐no ☐yes
Lightheaded or dizzy.....☐no ☐yes
Convulsions or tingling sensations...☐no ☐yes
Tremors..... ☐no ☐yes
Strokes/TIA..... ☐no ☐yes
Head injury..... ☐no ☐yes

Genitourinary

Frequent urination..... ☐no ☐yes
Burning or painful urination..... ☐no ☐yes
Blood in urine..... ☐no ☐yes
Sexual difficulty..... ☐no ☐yes
Irregular periods..... ☐no ☐yes
Psychiatric Memory loss/confusion ..☐no ☐yes
Nervousness/anxiety..... ☐no ☐yes
Depression..... ☐no ☐yes
Sleep problems..... ☐no ☐yes
Snoring..... ..... ☐no ☐yes

Respiratory

Frequent coughing..... ☐no ☐yes
Spitting up blood..... ☐no ☐yes
Shortness of breath..... ☐no ☐yes
Asthma or wheezing..... ☐no ☐yes

Endocrine

Glandular or hormone problem..... ☐no ☐yes
Thyroid disease..... ☐no ☐yes
Diabetes..... ☐no ☐yes
Excessive thirst or urination..... ☐no ☐yes
Heat or cold intolerance.....☐no ☐yes

Gastrointestinal

Loss of appetite..... ☐no ☐yes
Constipation..... ..... ☐no ☐yes
Nausea or vomiting..... ☐no ☐yes
Frequent diarrhea..... ☐no ☐yes
Blood in stool..... ..... ☐no ☐yes
Stomach pain..... ☐no ☐yes

Hematologic/Lymphatic

Slow to heal after cuts..... ☐no ☐yes
Easily bruise or bleed..... ☐no ☐yes
Anemia..... . ☐no ☐yes
Phlebitis..... . ☐no ☐yes
Transfusion..... ☐no ☐yes
Swollen glands.....☐no ☐yes

Any other problems not yet identified?

Heart Rate _____ _bpm **Temperature** _____ **Respiratory Rate** _____ /min **. Weight** _____ **Height** _____

☐**THC** ☐**OPI** ☐**AMP** ☐**COC** ☐**BZO** **Next Appointment:** _____

Consumer Name: D.O.B.: Insurance#: