

# West Side Cardiology Associates

## Patient Questionnaire for Follow-up Visit

Please complete this questionnaire for us. This information allows us to completely review your health. It will help facilitate your office visit so we may focus our time addressing your specific health concerns. Thank you.

Patient's Full Name:

Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_

<b>REASON FOR TODAY'S VISIT</b> _____ _____
<b>Do you need any medications refilled?</b> ___ Yes      ___ No

Check, if any of the following has **CHANGED** since your last visit:

### EYE, EAR, NOSE, THROAT

- Difficulty swallowing
- Hoarseness
- Hearing problems
- Nosebleeds
- Visual changes

### GASTROINTESTINAL

- Anemia
- Black or bloody stool
- Bloating
- Indigestion/ acid reflux
- Poor appetite

### GENERAL

- Allergy symptoms
- Chills/ Faint
- Dizziness
- Migraines/ Headache
- Pain to muscles or joints
- Weight gain/ loss

### GENITO/ URINARY

- Blood in urine
- Erection difficulties
- Frequent urination

### NEUROLOGICAL

- Loss of strength
- Numbness/ tingling
- Stroke/TIA

### CARDIAC/ PULMONARY/ VASCULAR

- Angina
- Asthma
- Atrial fibrillation
- Bleeding disorder/ bruising
- Blood clots

- Bronchitis
- Chest pain/ Pressure/ Discomfort
- COPD/ Emphysema
- Cough
- Diabetes

- Edema-(swollen legs, ankles, feet)
- Irregular heart beat
- Low blood pressure
- Palpitations
- Rapid heart rate

### CHANGES IN MEDICATIONS

Please include **ONLY CHANGES IN ALL** prescription and nonprescription medications. Please include vitamins, supplements, aspirin, birth control medications, laxatives, breathing treatments, medicines taken "as needed", etc. Use the back of this sheet if necessary.

	Name of Medication	Dose	How often taken	Prescribing Physician
1.				
2.				
3.				
4.				
5.				
6.				
7.				

To the best of my knowledge, all the information provided regarding my health, is complete and correct. I understand that it is my responsibility to inform West Side Cardiology if I have any changes in my health, or health information.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Please print name of Patient

Reviewed by: \_\_\_\_\_  
Physician

\_\_\_\_\_  
Date