

**RETURNING PATIENT QUESTIONNAIRE**

Please answer the following for your appointment. *Thank you.*

**Last Name**

**First Name**

**DOB**

**Have you had any new diagnoses since last being seen?** \_\_\_\_\_

**Have you had any change in your Medication List including doses since last being seen?** \_\_\_\_\_

**Review of systems:**

Please mark off if you have experienced any of these symptoms in the past couple weeks:

- General:  weight loss  weight gain  fevers  night sweats  fatigue  loss of appetite
- Eyes:  blurry vision  double vision  bright lights, flashing lights, spots or dots in vision  
 sensitivity to light  glaucoma  wavy lines, zigzag lines, swirly lines, kaleidoscope
- Ears, nose, mouth, throat:  hearing loss  muffled hearing  ringing in ears  dizziness (vertigo)  
 trouble swallowing  sinus pressure  nasal discharge  ear pain  
 Change in sense of smell or taste
- Cardiovascular:  shortness of breath  chest pain or pressure  palpitations (feeling of heart racing)  
 passing out spells  swelling in legs  low blood pressure  high blood pressure  
 lightheadedness upon standing
- Pulmonary:  cough  wheezing  coughing up blood
- Gastrointestinal:  nausea  vomiting  diarrhea  constipation  stool incontinence
- Genitourinary:  frequent urination  urgency  incontinence  trouble getting urine out  
 erectile dysfunction  low libido
- Neurological:  headache  memory loss  loss of consciousness  numbness or tingling  
 weakness  muscle cramps  tremor  lack of coordination  
 falls  falls resulting in injury  slowness of walking or movement  
 shuffling gait  stooped posture  reduced armswing  dragging feet  
 muscle stiffness  twitching or jerking  slurred speech  change in voice
- Psychological:  depression  anxiety  personality change  auditory hallucinations  
 paranoia  agitation  visual hallucinations  suicidal thoughts
- Sleep:  trouble falling asleep  trouble staying asleep  snoring  
 irregular breathing during sleep  kicking or punching during dreams  
 vivid dreams or nightmares  restless legs  sleeping too much during the day
- Endocrine:  cold intolerance  heat intolerance  enlarged size of hands or fingers  
 change in size of facial features  history of kidney stones  
*For women:*  irregular periods  menopause
- Skin / breast:  stretch marks  leaking from breasts  rash
- Musculoskeletal:  joint pain  joint swelling  muscle pain  reduced range of motion
- Hematologic:  bleeding  bruising  use of blood thinners
- Allergic/Immunologic:  environmental allergies  swollen lymph nodes  lumps or swelling

*Please verify the above is correct.* Patient / caregiver signature \_\_\_\_\_

**Are you open to receiving information about potential clinical trials and community events? Please include your email address** \_\_\_\_\_