INTERNAL MEDICINE PC

JM LORENTZEN D.O.

Follow up Consultation Form
INTERNAL MEDICINE, P.C.
J.M. Lorentzen, D.O.

Date:		**DOB**		**Age**		**Occupation**	
Name:							
Reason for visit today							
Allergies							

Medication (Prescriptions & over the counter medication) Include name, dosage, and frequency)

Medical Conditions, Illnesses, Injuries, Hospitalizations (check any that apply to you)

YES	NO		YES	NO	
		High Cholesterol			**Other thyroid disease**
		Circle those that apply:			Explain:
		Cholesterol Triglycerides LDL			**History of clotting disorder**
		High Blood Pressure			**Anemia** CBC date
		Treatment			**Varicose Veins**
		Low Blood Pressure			**Heartburn**
		Treatment			**Ulcers**
		Diabetes			**Constipation**
		Treatment			**Diarrhea**
		Migraine Headaches			**Other problems with stomach**
		Frequency age at onset			**or intestines**
		CT/MRI treatment			**Liver Problems** Resolved?
		Chest Pain/Heart attack			**Cancer**
		Stroke			Type
		Heart Murmur			Treatment
		Asthma or lung disease			last appt next appt
		Hypothyroidism			

New Surgery History since last appointment (women - see female consult form for female surgeries)

SOCIAL/PERSONAL HISTORY

Marital Status married single widow(er) separated

Education High School / GED Vocational Some College Bachelors/higher

Occupation

Do you have a Living Will/Advanced Directive created?

Do you exercise? If yes, describe type & frequency:

Do you use Tobacco products? If yes; type, frequency, years:

Do you drink alcohol? If yes, list type of alcohol and frequency of use.

Do you drink coffee, sodas, or other caffeinated beverages?

List types and amounts consumed daily?

IMMUNIZATIONS (please indicate date of last vaccines

FLU / H1N1: tetanus pneumonia

TB Skin Test (date and result) hepatitis B shingles

HEALTH MAINTENANCE

Last stool occult blood test:

Dental exam: Dilated Eye Exam Foot Exam

YES	NO	CONSTITUTIONAL
		Unexplained weight loss
		Unexplained weight gain
		Fever/sweats
		Chills
		Fatigue
		Nausea or Vomiting
YES	**NO**	**EYES**
		Cataract
		Change in vision
		Glasses
		Red eyes
		Headache
		change in frequency, intensity, duration?
YES	**NO**	**ENMT**
		Bleeding from gums
		Problems in your voice
		Denture
		Nose bleeds
		Hoarse voice
		Sinus problems
		Ringing in ears
		Mouth ulcers
YES	**NO**	**CARDIOVASCULAR**
		Angina
		Heart problems
		Chest pain
		Leg pain with walking
		Problems with exercise
		Swelling in Legs
		Problems lying flat
		Skipping heart beats
		Short of breath at night
		RESPIRATORY
		Bronchitis
		Cough
		Coughing up blood
		Shortness of Breath (at rest/with exertion)
		Wheezing
		Recurring respiratory infections
YES	**NO**	**GASTROINTESTINAL**
		Blood in stool
		Change in movements
		Constipation/diarrhea (circle)
		Food intolerance
		Difficulty swallowing
		Heart burn
		Hemorrhoids
		Black tarry stool
		Nausea/vomiting/bloating (circle)
		Stomach ulcers

YES	NO	Skin	Doctor's notes
		Skin changes	
		Skin lesions	
		Skin itching	
		Rashes	
		Dry Skin	
YES	**NO**	**GENITOURINARY**	
		Problems urinating	
		Blood in urine	
		Urinary frequency	
		Stress incontinence	
		Urination at night	
		Urinary urgency	
		Painful urination	
YES	**NO**	**MUSCULAR SKELETAL**	
		Neck pain	
		Gout	
		Injury to limbs	
		Joint Pain	
		Joint stiffness	
		Back pain	
		Red or Swollen joints	
YES	**NO**	**HEMATOLOGY/ONCOLOGY**	
		Anemia or low blood	
		Easily bruise	
		Swollen lymph nodes	
		Cancers	
YES	**NO**	**PSYCHIATRIC**	
		Depression or Sadness	
		Feel like hurting someone	
		Feel like hurting yourself	
		Anxiety	
		Problems concentrating	
		Difficulty falling asleep	
		Difficulty staying asleep	
		wake feeling refreshed	
YES	**NO**	**NEUROLOGY**	
		Changes in memory	
		Dizziness	
		Headaches	
		Imbalance	
		Numbness	
		Weakness	
		Tremors	
		Seizures	
YES	**NO**	**ENDOCRINE**	
		Problems with heat	
		Problems with cold	
		Swelling in neck	
		Increase thirst/perspiration (circle)	
		hair loss or increase (circle)	