Phone:
Fax:

Comprehensive Internal Medicine
Follow up Visit

1) Please List all current Medications and dosages you are taking, including over-the-counter, supplements, and herbal remedies.

Review of Systems

2) Have you recently (ie in the last 1-2 weeks) had any of the following:

- ❒ **Fever**
- ❒ **Change in weight**
- ❒ **Change in vision**
- ❒ **Runny Nose**
- ❒ **Nose bleeds / easy bruising**
- ❒ **Rash**
- ❒ **Swelling of the legs**
- ❒ **Shortness of Breath, Coughing or Wheezing**
- ❒ **Abdominal Pain**
- ❒ **Change in bowel habits**
- ❒ **Blood in the stool**
- ❒ **Headache**

Phone:
Fax:

CIM Follow up Visit Questionaire

- ❒ **Chest pains**
- ❒ **Dizziness/fainting**
- ❒ **Joint pains**
- ❒ **Depression Anxiety**

3) If you have been self-monitoring your blood pressure at home please include that information below:

4) If you have been self-monitoring your blood gluclose at home please include that information below: