



Follow Up History Form

First Name: _____

Last Name: _____

Date of Birth: _____

Today's Date: _____

History of Present Illness

What is the purpose of today's visit? _____

Routine Follow-up (no new problems)

I have a new problem or worsening symptoms. Please briefly describe: _____

Please update the following:

Past Medical History — List any new diagnoses or problems since last visit: _____

Allergies — List any new allergies since last visit: _____

Surgical History — List any surgeries that you have had since your last visit: _____

Medications — Please indicate any medication changes since last visit:

Name	Amount	Times per day	Name	Amount	Times per day

If the doctor prescribed medication for you at your last visit, was it helpful?

Yes No Medication Name: _____

Yes No Medication Name: _____

Yes No Medication Name: _____

Vital Signs

Height: _____

Weight: _____