**PATIENT FOLLOW UP FORM**

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| *NAME:* | *ADDRESS:* | *HOME PHONE #*  *CELL #* |
| *CURRENT MEDS:* | | *EMAIL ADDRESS:* |
| *ALLERGIES:* |
| *LIST OF PHYSICIANS PRESENTLY SEEING OR HAVE SEEN IN THE PAST YEAR.* | | |
| *RECENT SURGERIES OR HOSPITALIZATIONS WITHIN THE LAST YEAR* | | |
| *DO YOU CURRENTLY SMOKE? YES NO IF SO, HOW MUCH PER DAY?* | | |
| *ARE YOU CURRENTLY BEING TREATED FOR HIGH BLOOD PRESSURE?* | | |
| *HAVE YOU EVER HAD A COLONOSCOPY? YES NO*  *IF YES, DATE OF PROCEDURE:* | | |
| *ARE YOU CURRENTLY RECEIVING CHEMOTHERAPY? YES NO* | | |
| *HAVE YOU HAD ANY RECENT SCANS OR PROCEDURES DONE IN THE LAST YEAR? YES NO* | | |
| *IF YES, PLEASE LIST TYPE OF SCAN/PROCEDURE, DATE, AND FACILITY* | | |
| *IF MALE, LIST DATE OF LAST PSA?* | | |
| *IF FEMALE, LIST DATE OF LAST MAMMOGRAM?* | | |
| *IF FEMALE, LIST DATE OF LAST PAP SMEAR* | | |
| *DO YOU HAVE A LIVING WILL?* | | |

**I attest that all of the information in this document is true and correct to the best of my knowledge and understand my physician will base his opinions and judgments on the same.**

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**Patient Signature Date**