CLINIC PROGRESS NOTES

Name: _____ **Date:** _____

Since your last clinic visit:

1. Have you been in the hospital or surgeries? ☐Yes ☐No If yes, explain _____
2. Have any of your medicines changed? ☐Yes ☐No If yes, explain _____
3. Have you had any exposure to IV-dye? ☐Yes ☐No If yes, explain _____
4. Are you taking pain medications? ☐Yes ☐No If yes, explain _____
5. Any new medical problems? ☐Yes ☐No If yes, explain _____
6. Any deaths or illnesses in your family? ☐Yes ☐No If yes, explain _____
7. If you have diabetes:
   - When was your last eye exam? _____
   - When was your last foot exam? _____

Please complete the section below, if this is your first visit OR if you have been seen in the past, please circle any issue(s) developed since your last visit.

Constitutional

Weight loss/gain	Yes	No
Dizziness	Yes	No
Light Headedness	Yes	No

Eyes

Vision changes	Yes	No
Pain	Yes	No
Periorbital Edema	Yes	No
Laser Treatment	Yes	No
Retinopathy	Yes	No

Ears, Nose, Mouth, Throat

Ear or Throat Pain	Yes	No
Hearing difficulty	Yes	No
Chronic Sinus trouble	Yes	No
Headache	Yes	No

Cardiovascular

Chest Pain	Yes	No
Skipped beat	Yes	No
Swollen legs	Yes	No

Respiratory

Shortness of breath	Yes	No
Cough	Yes	No
Wheeze	Yes	No
Loud Snoring	Yes	No
Blood in Sputum	Yes	No
Sleep Apnea	Yes	No

Gastrointestinal

Belly Pain	Yes	No
Nausea/Vomiting	Yes	No
Diarrhea/Constipation	Yes	No
Taste loss	Yes	No
Blood/Dark stools	Yes	No
Appetite Change	Yes	No

Genitourinary

Difficulty urinating	Yes	No
Uncontrolled urination	Yes	No
Bloody urine	Yes	No
Urinary frequency	Yes	No
Foaming	Yes	No
Infection	Yes	No
Kidney Stone	Yes	No

Musculoskeletal

Joint, back, neck pain	Yes	No
Muscle pain	Yes	No
Arthritis	Yes	No
Pain Medication	Yes	No

Skin

Rash	Yes	No
Itching	Yes	No

Neurologic

Weakness	Yes	No
Tremors	Yes	No
Numbness/tingling	Yes	No
Mini Stroke	Yes	No

Psychiatric

Hopelessness	Yes	No
Depressed	Yes	No

Endocrine

Heat/Cold Intolerance	Yes	No
Tired or sluggish	Yes	No
Increased drinking	Yes	No
Increased urination	Yes	No
Blood Sugar Controlled	Yes	No

Hematologic/Lymphatic

Bruising/bleeding	Yes	No
Clots	Yes	No
Blood transfusions	Yes	No
Epogen/Procrit	Yes	No

Allergic/Immunologic

Hay fever	Yes	No
Drug allergies	Yes	No

Physician Use:

☐ PMH Reviewed	☐ No Change	☐ Updated
☐ P51-I Reviewed	☐ No Change	☐ Updated
☐ FHx Reviewed	☐ No Change	☐ Updated
☐ 5Hx Reviewed	☐ No Change	☐ Updated
☐ Allergies	☐ No Change	☐ Updated

Physician _____