



Return Visit Form

A NEWLIFE CLINIC

Name: _____ Date: _____

Chief complaint: _____

Please answer if it applies to you.

Diabetes:

What was your last Blood Sugar & Number _____
What was your last HgA1C _____
When was your Cholesterol last checked _____
Last Dental exam _____
Last Eye exam _____
Take aspirin daily _____
Any wounds on the feet _____

Others:

Are you taking any supplements _____
Are you interested in taking
supplements _____

Weight Management:

Any weight gain or loss since last visit _____
How are you doing with food? _____
Exercise _____ what type and how long and often _____
Goal for next Month _____
Do you have support _____

Any Medication changes? _____

Please Circle ones that apply to you:

Review of System:

Gen: Wt changes
Fatigue
Fever
Chills
Night sweat

Resp: Shortness of Breath
Wheezy
Coughing
sputum
bronchitis
asthma

GI/GU: Constipation
diarrhea, nausea, vomiting
indigestion, bleeding
abdominal pain, stool color change
stool habit changes, urinary
frequency, pain urinating, hesitancy
Urinary, blood in urine.

Skin: moles
Sores
Itching
Dryness

Cardiac: palpitation
swelling
shortness of breath
at night, high blood pressure
High blood pressure, irregular
Heart beet

Endocrine: heat/cold intolerance
excessive sweating
high blood sugar
Mental: depression, tension
memory loss, anxiety, mood swings

Heent: glasses
Contact lenses, blindness
Itchy, hearing loss, vertigo, ring in ear
Earache, stuffiness, sneezing, runny nose
Sinus pain

Nuero: loss of sensation
numbness, weakness, seizures, fainting
spells

Muscular: Stiffness, neck, back pain, spasm