DR. JAMES F. WYSS

* PATIENT FOLLOW UP VISIT FORM *

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NAME: _____ TODAY'S FOLLOW UP VISIT DATE: _____

REASON FOR TODAY'S VISIT: _____

PLEASE UPDATE US ON YOUR CHIEF COMPLAINT / CONDITION ADDRESSED AT INITIAL VISIT WITH DR. WYSS:
(i.e. improvement in function, change in pain)

_____

_____

TREATMENTS COMPLETED (physical therapy, medication, etc): _____

_____

% OF IMPROVEMENT: _____

CIRCLE BEST & **WORST** PAIN LEVEL (0 = No Pain, 10 = Extreme Pain) 0 1 2 3 4 5 6 7 8 9 10

WHAT MAKES YOUR PAIN WORSE_____

WHAT MAKES YOUR PAIN BETTER_____

LIST ANY CHANGES REGARDING YOUR PAST MEDICAL, SURGICAL, FAMILY OR SOCIAL HISTORY:

_____

_____

ARE YOU TAKING ANY NEW MEDICATIONS: Yes No

If Yes please list new medications: _____

ARE THERE ANY NEW PROBLEMS YOU WOULD LIKE TO DISCUSS TODAY? _____

_____

PATIENT SIGNATURE_____ DATE_____

REVIEWING PHYSICIAN SIGNATURE_____ DATE_____

_____

OFFICE USE ONLY:

Height: _____ Weight: _____ B/P: _____ Pulse: _____