Dr. Bawa and Associates: Follow up Form

Do you currently have any of the following problems? No current problems ☐

GENERAL/CONSTITUTIONAL		HEAD, EYES, EARS, NOSE, THROAT		CARDIOVASCULAR	
Fever or Chills	☐YES ☐NO	Headache	☐YES ☐NO	Chest pain or pressure	☐YES ☐NO
Night Sweats	☐YES ☐NO	Eye pain or Irritation	☐YES ☐NO	Chest tightness	☐YES ☐NO
Other:		Tearing or Discharge	☐YES ☐NO	Palpitations	☐YES ☐NO
		Nasal or Sinus Discharge	☐YES ☐NO	Edema	☐YES ☐NO
		Sinus pain or pressure	☐YES ☐NO	Other:	
		Dizziness	☐YES ☐NO		
RESPIRATORY		**GASTROINTESTINAL**		**GENITOURINARY**	
Shortness of Breath	☐YES ☐NO	Nausea	☐YES ☐NO	Difficulty Urinating	☐YES ☐NO
Chest Congestion	☐YES ☐NO	Vomiting	☐YES ☐NO	Decreased urination	☐YES ☐NO
Cough	☐YES ☐NO	Abdominal Pain	☐YES ☐NO	Blood in Urine	☐YES ☐NO
Wheezing	☐YES ☐NO	Other:		Other:	
MUSCULOSKELETAL		**INTEGUMENTARY**		**NEUROLOGICAL**	
Joint swelling	☐YES ☐NO	Hives/urticaria	☐YES ☐NO	Seizures	☐YES ☐NO
Joint stiffness	☐YES ☐NO	Skin Cancer	☐YES ☐NO	Tingling or numbness	☐YES ☐NO
Muscle or joint pain	☐YES ☐NO	Pain	☐YES ☐NO	Tremors	☐YES ☐NO
Other:		Breast lump	☐YES ☐NO	Other:	
HEMATOLOGIC/LYMPHATIC					
Spontaneous or excessive bleeding	☐YES ☐NO				
Slow to heal	☐YES ☐NO				

Are you here to discuss any Lab results? **Yes** **No**
If so, did you have blood work with (circle one) Quest labs Labcorp Saliva Test

Do you have imaging tests we need to pull up? **Yes** **No**
If so, did you have the imaging done at (circle one) Sacred Heart Fort Walton IDI imaging

Were you recently in the Emergency room or admitted in the hospital? **Yes** **No**
If so, circle which hospital (circle one) Sacred Heart Fort Walton Twin Cities

Do you need any refills? **Yes** **No**
If so, list what meds you need refilled today_____

Please list the top 3 reasons for today's Visit

1. _____
2. _____
3. _____

We are required to grant online access to your records electronically. Would like to set that up?
Email address_____ **Yes** **No**

ALL Patients Please Answer these Questions
Have you had a colonoscopy? Yes No
Have you had a tetanus vaccine in the last ten years? Yes No
Have you had the two pneumonia vaccines? Prevnar and Pneumovax Yes No

Diabetics ONLY Please Answer These Questions
Have you had your hemoglobin a1c (Hgb a1c) checked? Yes No

See Reverse Side

Have you had eye exam? Date of exam_____?	Yes		No	
Do you take Baby aspirin ?		Yes		No
Do you have problems with feet? Have you had a foot exam? Date _____	Yes		No	

Would you like information on:

Skin tightening options?	Yes	No
Removing smile lines?	Yes	No
Removing sun spots?	Yes	No
Reducing frown lines?	Yes	No
Scar Removal?	Yes	No
Laser Hair Removal for Men?	Yes	No
Laser Hair Removal for Women?	Yes	No
Laser Vein Removal?	Yes	No
Coolsculpting to reduce love handles, saddle bags, muffin top?	Yes	No
Reduce excessive sweating under arms	Yes	No
Reducing circles under eyes?	Yes	No
Hand Rejuvenation to reduce the appearance of aging in hands	Yes	No
IV therapies to help with fibromyalgia, fatigue and chronic conditions	Yes	No
Botox to prevent migraines	Yes	No
Allergy Testing & Immunotherapy to help with allergies & asthma	Yes	No

For Office Use Only

Height _____ Weight_____ Temp_____

Pulse_____ BP_____ Respiration Rate_____