Steven Locke, MD 10 Deer Run, Wayland, MA 01778 508-358-4672

PATIENT F/U QUESTIONNAIRE, MEDICAL SUPPLEMENT

Please complete this questionnaire as fully as possible and bring it to your appointment.

Name _____ D. O. B. _____ Date _____

Have you noticed any of the following symptoms or problems in the last month? Check all that apply.

- ☐ fevers
- ☐ fatigue
- ☐ weight loss
- ☐ changes in your vision
- ☐ double vision
- ☐ eye pain or irritation
- ☐ hearing loss
- ☐ ringing in your ears
- ☐ ear pain
- ☐ sore throat
- ☐ nose bleeds
- ☐ runny nose
- ☐ sores in your mouth
- ☐ shortness of breath
- ☐ persistent cough
- ☐ wheezing
- ☐ chest pain
- ☐ rapid heart beat or palpitations
- ☐ swelling of legs or ankles
- ☐ nausea or vomiting
- ☐ diarrhea
- ☐ constipation
- ☐ abdominal pain
- ☐ blood in your urine
- ☐ painful urination
- ☐ difficulty passing urine
- ☐ sexual problems
- ☐ decreased interest in sex
- ☐ joint pain or swelling
- ☐ aches or pains in your arms or legs
- ☐ back pain
- ☐ breast swelling, masses, or discharge
- ☐ skin rashes or sores
- ☐ headaches
- ☐ dizziness, light-headedness, or vertigo
- ☐ numbness or tingling
- ☐ tremors
- ☐ problems with balance or coordination
- ☐ changes in menses
- ☐ hair loss
- ☐ increased thirst
- ☐ increased urinary frequency
- ☐ easy bruising
- ☐ bleeding from gums
- ☐ allergic reactions
- ☐ other medical symptoms

Since your last visit...

Have you seen a doctor for a medical condition?	__Y	__N
Have you gone to the ED or been hospitalized?	__Y	__N
Has anyone in your family become ill or died?	__Y	__N
Have you had new side effects to a medication?	__Y	__N

IF YES to any of above, please provide details: