



FOLLOW UP HEALTH QUESTIONNAIRE

Provider: ___ ROBERT A. ROVNER, MD
 ___ VIKRAM TALWAR, MD

Patient Name: _____ Date of Birth: _____ Age: _____

Height: _____ Weight: _____

What is the reason for today's visit/chief complaint?:

Do you need a work note or forms completed? Yes No Form/note type: _____

Do you need a prescription or refill? Yes No If so, what medication: _____

Pain level today (1-10): _____

What are your current symptoms:

New Medications Since LAST VISIT(including OTC/vitamins/herbals/supplements) **No Changes**

Medication	Dosage & Frequency	Purpose & Administered route i.e. oral/IV/topical	Physician

Do you have any drug allergies? Yes No If so, list: _____

Treatment Since LAST VISIT **No Changes**

	YES	NO	Number of Visits	Facility
Physical Therapy				
Chiropractic				
Acupuncture				
Injections				

-Type(i.e epidural, facet, ablation):

Medications: Please List				
Brace				
Home Exercise Program				
Surgery: _____				

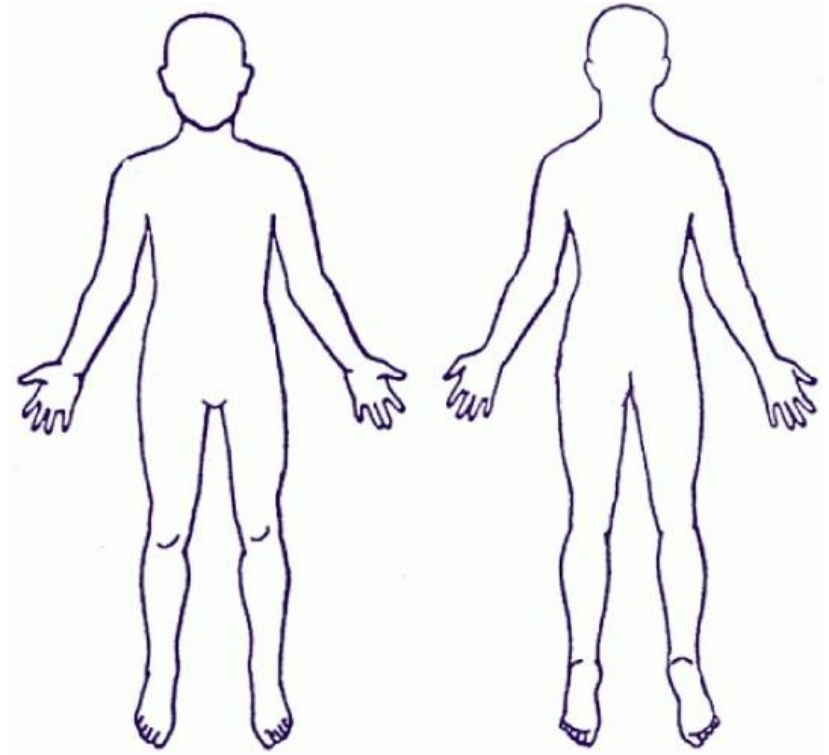
Diagnostics Since LAST VISIT **No Changes**

	YES	NO	Body Part	Facility
MRI / CT				
X-Ray				
EMG/ Nerve Conduction Study				
Other:				

Patient Name: _____

Date of Birth: _____

Below "X" the areas you feel pain



Please describe your pain:

Have you been diagnosed with a new illness or had any changes in your health since we last saw you?

Yes No If yes, what is it:

Have you had a fall in the last 12 months? Yes No

More than 2 times? Yes No

Office use:

Pulse: _____ BP: _____ BMI: _____

General Appearance: Well nourished Not well nourished Stand Normally Doesn't stand normally

Oriented x 3: Awake Responsive Oriented of person/place/time

Mood and Affect: Normal Not Normal

Patient Signature

(Date)

Provider Signature

(Date)