SPARKS & FAVOR, P.C.

RETURN VISIT CHART # ___________________

Date: ___________________________________ Age: ___________ Date of Birth: ______________________

Name: ___________________________________ Occupation: ______________________

Email Address: ___________________________ Spouse/Partner's Name: ______________________________

REASON FOR VISIT: (please circle): Annual Visit Problem (Description)_______________________________

Referred by: _____________________________ Primary Care Doctor: ________________________________

CURRENT MEDICATIONS

Drug Name	Dosage	Prescribed by	Drug name	Dosage	Prescribed by

ALLERGIES TO MEDICATIONS/SUBSTANCES	LIST:
List all natural or herbal remedies over-the-counter drugs, vitamins, minerals you are taking	LIST:

PAST MEDICAL/FAMILY HISTORY UPDATE

CHANGES? YES ___ List:
NO ___

Tobacco Use	**yes ____**	**no ____**
Alcohol Use	**yes ____**	**no ____**
Family History of blood clots?	**yes ____**	**no ____**
Contraceptive Choice? N/A	____________________	

SURGERY/HOSPITALIZATION UPDATE No Changes ____

Procedure	Date	Procedure	Date	Procedure	Date

GYNECOLOGIC UPDATE

Date of last period?	How many days between periods?	Do you pass clots? Yes No
How many days does period last?	Flow: Light Medium Heavy	Bleeding between periods? Yes No

REVIEW OF SYMPTOMS (Please mark all that apply)

Symptoms	Yes	Symptoms	Yes	Symptoms	Yes
Constitutional		**Respiratory**		**Musculoskeletal**	
Fatigue		**Cough**		**Joint pain**	
Fever		**Shortness of breath**		**Muscle pain**	
Weight Loss		**Wheezing**		**Muscle weakness**	
Weight Gain		**Coughing up Blood**		**Endocrine**	
Other:		**Gastrointestinal**		**Heat/cold intolerance**	
Eyes, Ears, Nose & Throat		**Nausea/vomiting**		**Hair loss**	
Impaired Vision		**Constipation**		**Hot flashes**	
Vision Change		**Blood in stool**		**Night sweats**	
Headache		**Diarrhea**		**Psychiatric**	
Sore Throat		**Genitourinary**		**Anxiety**	
Lightheadedness		**Urgency to urinate**		**Depression or frequent crying**	
Sinusitis		**Frequency of urination**		**Difficulty sleeping**	
Ulcers		**Painful urination**		**Hematologic**	
Breast		**Blood in urine**		**Easy bruising**	
Lumps		**Incomplete emptying of bladder**		**Bleed easily**	
Tenderness		**Incontinence**		**Enlarged lymph glands**	
Swelling		**Skin**		**Blood transfusions**	
Nipple Discharge		**Rash**			
Cardiovascular		**Moles (new growth or changes)**			
Chest Pain		**Neurologic**			
Irregular heart beat		**Numbness**			
		Memory Difficulties			
		Seizures			

FORM COMPLETED BY: ____ Patient ____ OFFICE NURSE ____ PHYSICIAN _____ OTHER __________________________

Signature of Patient: ____________________________ Signature of Physician ___________________________