DR. JAMES F. WYSS

* PATIENT FOLLOW UP VISIT FORM *

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: ____________