

Follow up Visit: ____/____/____

Please circle any positive symptoms listed below:

Name: _____ DOB: / / Today's date: _____

HOW ARE YOU FEELING TODAY?

Have you been in the hospital recently? Yes No -If yes what was the reason!

Are you participating in our @ home Blood Pressure Monitoring Program? YES NO

Are you able to urinate? 1. Same as usual 2. More than usual 3. Less the usual

Is your urine: clear –yellow dark-yellow cloudy red like Coca-Cola

Do you have: blood in the urine? Frothy urine? Pain while urinating?

Have you had any infection in the urine recently? Yes No

Do you have the sensation of not emptying your bladder completely after you finished urinating? Yes No

Have you found it difficult to postpone urination? Yes No

Do you have to push or strain to begin urination? Yes No

Do you have a weak urinary stream? Yes No

Are you losing (leaking) urine with cough or exercise Yes No

Do you have to urinate during the night? Yes No If yes! How many times?.....

Do you have pain around your kidneys (flanks)? Yes No If yes 1. Right 2. Left 3. Both

Do you eat with salt? 1. None 2. A little 3. Moderate 4. A lot!

How much water/liquids do you drink per day?.....

Do you have swelling in your legs? 1. No 2. Some 3. Moderate 4. a lot

The swelling in your legs is it getting: 1. Worse 2. Better 3. Did not change in the last period of time

Did your weight change recently? 1. No change 2. Gained weight 3. Lost weight

Do you feel short of breath? 1. No 2. Some 3. Only when I walk 4. At rest 5. All the time 6. Only when I am lying flat

Is it getting: 1. Worse 2. Better 3. Did not change in the last period of time

Your appetite is: 1. Normal 2. Decreased 3. Nonexistent 4. Increased

How many times do you miss your medications per week?

1. Never 2. One time /week 2. Two times /week 3. More than two times /week

Do you check your blood pressure at home? Yes No If yes, what are the values?...../.....

Do you check your blood sugar at home? Yes No If yes, what are the values?.....

FLIP PAGE OVER ----->

Do you take any medications like: Motrin, Ibuprofen, Advil, Aleve, Naproxen, Celebrex, Indomethacin, ALFA-Lipoic Acid

Other pain killers:-**please list:**

Do you take any other medication/ supplements other than prescribed? Yes No

If yes which ones?-

Were you prescribed any new medication lately (last month)? Yes No

If yes please list:

Have you had any procedures done recently? Yes No *-If yes-please list:*

General: Fever Fatigue/Tired Chills Weakness

Eyes: Decreased vision Eye pain Eye redness Double vision Dry eyes

Ears/Nose /Throat: Decrease hearing Ear pain Ear drainage Sinus problems Sore throat Nose bleeds
Nose drainage Headaches Hoarseness Buzzing in your ears Dizziness Teeth pain or infections

Respiratory: Cough **Sputum:** white yellow green bloody **Wheezing** Night Sweats

Can you take a flight of stairs without feeling short of breath? Yes No

Cardiac: Chest pain/pressure within the last 4 weeks Palpitations Pain in your calves while walking?

Do you get up in the middle of the night because of shortness of breath? Yes No

Gastro: Metallic taste Abdominal pain Nausea Vomiting Heart burns Diarrhea Constipation
Bloody or Black stools Trouble swallowing

Joints/Muscles: Back pain Neck Pain Joint pain Joint swelling Muscle pain Leg Cramps

Skin changes: Rashes Itching

Neurological: Numbness Tremor Tingling Seizures Memory loss **jerking** movements fainting

Psych/ Sleep: Depression Insomnia Sleepiness Snoring Day time drowsiness Anxiety

Endocrine: Heat intolerance Increase thirst Increase water/fluid intake Hair loss **too** much hair

Hematologic: Bleeding gums Easy bruising Enlarged lymph nodes Bone pain

Allergy: Seasonal allergies Hives

Please list any other significant problems that are bothering you: