Heart, Vascular & Vein of Tampa Bay

Consultative, Diagnostic & Interventional Cardiac, Vascular & Venous Disease

FOLLOW UP VISIT QUESTIONNAIRE

PATIENT NAME: ______________________________ **DATE:** _________________ **DOB:** _________________

CURRENT PHONE # _________________ **EMAIL ADDRESS (OPTIONAL)** ______________________________

Please answer questionnaire so that we may update your file:
Since your last visit with us, are there any changes in your history:

1)	Did you change your Primary Care Physician? IF YES Describe:	
2)	What is your local pharmacy? Who is your mail order pharmacy?	Describe: Describe:
3)	Have you been hospitalized?	IF YES Describe:
4)	Do you have any medical problems?	IF YES Describe:
5)	Have you had any new surgery?	IF YES Describe:
6)	Do you have any changes in medications?	IF YES Describe:
7)	Do you have any new allergies?	IF YES Describe:
8)	Any changes in marital status?	IF YES Describe:
9)	Have you had any changes in habit(s) i.e., (smoking, alcohol, drug use, etc.)	IF YES Describe:
10)	Any family members with new cardiovascular problems?	IF YES Describe:
11)	Have you seen a specialist?	IF YES Describe:
12)	Do you have a Living Will?	☐ YES ☐ NO
13)	Do you have Advanced Directives?	☐ YES ☐ NO
14)	Do you have Health Care Surrogates?	☐ YES ☐ NO
15)	Do you need any medication refills today?	**(If YES, list medications below)**

1)	4)
2)	5)
3)	6)

Patient Signature: ______________________________ Physician Signature: ______________________________

NOTES - OFFICE USE ONLY: