Duke Surgery
DUKE UNIVERSITY MEDICAL CENTER

Division of Otolaryngology—Head and Neck Surgery

PATIENT RETURN VISIT FORM

Patient Name: ______________________________ **Duke #:** _____________ **Date:** ____________

Reason for today's visit: ____

Since your last visit, have you been diagnosed with any **new medical problems**?
☐ **NO** ☐ **YES** - - Please list
____

Since your last visit, have you developed any **new allergies**?
☐ **NO** ☐ **YES** - - Please list
____

Since your last visit, have you had any **new surgeries**?
☐ **NO** ☐ **YES** - - Please list
____

CURRENT MEDICATIONS: ☐ **NONE**
(Please give names, dosages, and frequency of any medications you are taking.)

- ☐ Antibiotics ____________________
- ☐ Anxiety (i.e., Valium, Prozac, Xanax,) ____________________
- ☐ Aspirin ____________________
- ☐ Blood Thinner (i.e., Coumadin,etc) ____________________
- ☐ Heart Pills ____________________
- ☐ Blood Pressure ____________________
- ☐ Diabetes(i.e.,Insulin) ____________________
- ☐ Allergy/Sinus ____________________
- ☐ Pain ____________________
- ☐ Sleeping ____________________
- ☐ Steroids ____________________
- ☐ Stomach/Ulcer(i.e., Prilosec, Zantac, etc) ____________________

Other: ____
____
____
____
____
____

(Please complete next page)

CURRENT PROBLEMS: (Please mark all appropriate responses to the following.) If answer is other, please state the problem.

CONSTITUTIONAL: ☐ **NONE**
- ☐ Weakness
- ☐ Fever
- ☐ Weight Loss
- ☐ Weight Gain

Other: ______________________________

SKIN ☐ **NONE**
- ☐ Lumps
- ☐ Rash
- ☐ Itching
- ☐ Lesions

Other: ______________________________

EYES: ☐ **NONE**
- ☐ Itching
- ☐ Excess Tearing
- ☐ Change in Vision
- ☐ Double Vision

Other: ______________________________

EARS: ☐ **NONE**
- ☐ Pain
- ☐ Swelling
- ☐ Discharge
- ☐ Loss of hearing
- ☐ Ringing/Buzzing
- ☐ Dizziness/Imbalance

Other: ______________________________

NOSE: ☐ **NONE**
- ☐ Obstruction
- ☐ Discharge
- ☐ Bleeding
- ☐ Loss of smell

Other: ______________________________

MOUTH/THROAT: ☐ **NONE**
- ☐ Sores/Ulcers
- ☐ Throat Pain
- ☐ Difficulty swallowing
- ☐ Voice Changes

Other: ______________________________

NECK: ☐ **NONE**
- ☐ Stiffness
- ☐ Lumps/Swelling
- ☐ Pain

Other: ______________________

HEART/LUNGS: ☐ **NONE**
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Cough

Other: ______________________________

DIGESTIVE/URINARY: ☐ **NONE**
- ☐ Heartburn/Indigestion
- ☐ Nausea/Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Burning with Urination
- ☐ Urinary incontinence
- ☐ Urinary retention

Other: ______________________________

NERVOUS/VASCULAR: ☐ **NONE**
- ☐ Headache
- ☐ Numbness
- ☐ Tremor

Other: ______________________________

This information has been reviewed with the patient. Follow-up information will be forwarded to your physician in a timely manner.

Patient Signature: ____

Physician Signature: ____