Miodrag Velickovic, M.D.
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Follow-up visit patient questionnaire

Name: _________________________ **Today's date:** _____ / _____ / _____

Current Insurance: ______________________ **ID#**______________________**SIGNATURE:**_____________________

Secondary Insurance: _____________________ **ID#**______________________**SIGNATURE**_____________________

Purpose of today's visit: ___________ **IF YOU SUFFER FROM SEIZURE, CONVULSIVE DISORDER, EPILEPSY, FAINTING OR DIZZY SPELLS, OR ANY CONDITION WHICH CAUSES UNCONCIOUSNESS NYS LAW REQUIRES THAT YOU DO NOT DRIVE FOR 1 YEAR AFTER THE LAST EVENT.**

Please LIST YOUR CURRENT MEDICATIONS (please **UNDERLINE** any new medications since your last visit here):

Medications time:								Notes

Did you change the dose of any medication? If so,why?

Family history: Social History: Smoking Y N Alcohol Y N Drug use Y N

Do you have any allergies**?**

Since your last visit, has there been any change in your general medical status?

Since your last visit, have you undergone any surgery/procedure?

Are you experiencing any of the following: (Please use the back of the page to elaborate when pertinent.)

Fever	Y	N	Cough	Y	N	Skin problem	Y	N	Sleepiness/ sedation	Y	N
Visual changes	Y	N	Constipation /Diarrhea	Y	N	Bleeding or bruising	Y	N	Difficulty sleeping	Y	N
Hearing loss	Y	N	*Hot flushes or Impotence*	Y	N	Headaches	Y	N	Anxiety	Y	N
Heart disease	Y	N	Bone/ Joint pain	Y	N	Change in mental acuity/memory	Y	N	Depression	Y	N

PATIENT SIGNATURE:____

Patient unable to provide ROS/medication list due to impaired mental status form current or chronic illness and/sedation/intubation

Reviewed by: _______________________ ☐ **All other systems are negative**

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CONSENT TO RECEIVE THE APPOINTMENT REMINDERS THROUGH MOBILE PHONE TEXT MESSAGING

____

Last name Middle name First name

Birth Date: / /

Mobile phone number: ________________________________

Patient's Signature:______________________________ **Date:_____________**