SAMEER H. NAGDA, M.D./MARCELLA ROACH, PA-C
FOLLOW-UP VISIT FORM

NAME:__________________________________________________    TODAY’S DATE:___________

PREFERRED EMAIL: _______________________________________________________________________

PRIMARY CARE PHYSICIAN: _______________________________________________________________

PREFERRED PHARMACY: (Name and #): _____________________________________________________

CHIEF COMPLAINT: SHOULDER     ELBOW      KNEE       ANKLE          OTHER:___________________
(please circle)

REASON FOR VISIT:________________________________________________________________________

_____________________________________________________________________________________

HOW SEVERE IS YOUR PAIN (On a scale of 0-10 with 10 being the worst pain ever felt)? ___________

HAS THE ISSUE BEEN (please circle one):  WORSENING      IMPROVING      THE SAME

OTHER SYMPTOMS:________________________________________________________________________

WHAT TREATMENTS HAVE YOU HAD SINCE YOUR LAST VISIT (circle all that apply):

NONE  X-rays     MRI     EMG        Physical Therapy  Ice

Heat  Medications  Injections  Surgery  Other________________

HAVE ANY OF THESE TREATMENTS HELPED:  YES      NO

IF SO WHICH TREATMENT: __________________________________________________________________

HAVE YOU RECENTLY EXPERIENCED ANY OF THESE SYMPTOMS:   YES_______(circle all that apply):

NUMBNESS / TINGLING      CHEST PAIN     STOMACH PAIN       NONE

SINCE YOUR LAST VISIT ON _________HAS THERE BEEN ANY CHANGE(S) IN YOUR MEDICAL HISTORY?

NONE _____ YES_____ IF YES, PLEASE EXPLAIN: _______________________________________________

________________________________________________________________________________________

Patient Signature:______________________________________ Date:___________________________

(Or the person who is filling out this form)

Below for office use only:

Height: ___________ Weight: ___________ R:___________

PE:

Assessment: __________________________________________

Signed:________________________