



Patient Label

**Follow Up Patient Information Sheet**  
**Informacion de el Paciente**

**New Address & Phone Number/ Direccion & Nuevo Telefono**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Current Medications/ Medicamentos:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Changes in your history since your last visit**  
**Cambio Historial de salud desde la última visita**

**New Diagnosis/ Nuevo Diagnostico**

\_\_\_\_\_

**Hospitalizations/ Hospitalizaciones**

\_\_\_\_\_

**Surgeries/ Cirujias**

\_\_\_\_\_

**Current Concerns/ Preocupaciones Nuevas**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Email Address/ Correo Electronico**

\_\_\_\_\_

**Would you like to be on our email newsletter list?**

Yes  No

(All email addresses will remain confidential and emails will be sent by Bcc)

**REVIEW OF SYSTEMS/ INFORMACION DEL PACIENTE:**

Weight loss or gain/ Perdida/ Aumento de peso	Yes	No
Headaches/Dolor de cabeza	Yes	No
Excessive thirst/Mucha sed	Yes	No
Over-eating/ Comiendo de mas	Yes	No
Vision,hearing problems/Problemas de vision/oídos	Yes	No
Frequent infections/ Infecciones	Yes	No
Feeling very hot or cold/ Escalofrios/Calor	Yes	No
Cough/ Tos	Yes	No
Heart flutters/Palpitaciones	Yes	No
Any pain/ Dolores	Yes	No
Diarrhea/ Diarrea	Yes	No
Constipation/ Estreñimiento	Yes	No
Rashes/ Sarpullidos	Yes	No
Dry skin/ Piel seca	Yes	No
Stretch Marks/ Estrías	Yes	No
Abnormal hair growth/Bello anormal	Yes	No
Abnormal body odor /Olor anormal	Yes	No
Development of puberty/ Precoz	Yes	No
Numbness of hands or feet/Entumidez de pies o manos	Yes	No
Trouble sleeping/ Insomnio	Yes	No
Behavioral Changes/ Cambio de Temperamento	Yes	No
Hair loss/ Perdida de cabello	Yes	No

**INSULIN (for diabetics only)**

Time	Insulin/a	Carb Ratio
<b>Breakfast/ Desayuno</b>		
<b>Lunch/ Lonche</b>		
<b>Dinner/ Cena</b>		
<b>Bedtime/ Noche</b>		
<b>Blood sugar Corrections/ Correccion</b>		