melmed center

Dear Patient,

We are looking forward to seeing you, at the upcoming follow-up visit.

Please complete the attached forms for your upcoming appointment.

Thank you for coming to your appointment prepared.

Have a great day!

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Consultation

melmed center ™

Name:_____DOB:_____ Date of Visit: _____

Accompanied By: _____ PCP: _ Time of Appointment:_____

I. **What is your chief concern/purpose of today's visit?**

_____

_____

II. **How are you doing?** (include work/school/friends/relationships)

_____

_____

_____

_____

_____

_____

What are some goals you have set? What is standing in the way of progress?

_____

_____

_____

III. **Do you have any reports or other information for us to see today?** (Reports reviewed)

_____

_____

_____

Please list target symptoms identified at previous visit and rate any change

1._____ _____Better Same Worse

2._____ _____Better Same Worse

3._____ _____Better Same Worse

4._____ _____Better Same Worse

Please turn over→

Patient Name:_____Date of Visit: _____

IV. What interventions are being used?

- **Please specify any educational or therapy programs and any progress or response seen?**

_____

_____

_____

_____

- **What non-medicinal products (dietary, supplements, etc.) are being used and note any progress seen?**

_____

_____

_____

- **Please specify <u>all</u> current medication(s)**: o none_____o daily_____o weekdays only _____

  o 1 _____ Dosage_____

  o 2 _____ Dosage_____

  o 3 _____ Dosage _____

Please circle family's attitudes towards medication? Positive Negative Please explain: _____

Please circle overall treatment improvement: none little moderate much exceptional

Have there been any other symptoms or side-effects? o none o insomnia

o sleepiness o headache o anger o palpitations o appetite increase o appetite loss

o stomachaches o nausea o rebound o irritability o personality change o tics

o fainting o activation o disinhibition o crying o constipation o involuntary movements

o snoring o teeth grinding o dizziness o weight gain o other _____

o Please circle if these preceded the use of medication? Yes No

Are there any significant family stressors or illnesses or anything else you would like us to know? For example, family history of heart disease, sudden death, suicide, etc.?

_____

_____

This section will be reviewed with your provider (check √ for normal/no complaints; and + for abnormal and/or complaints):

General/Constitutional	ENT	Respiratory	Genitourinary	Skin	Hematology
Eyes	Heart	Gastro-intestinal	Muscular-skeletal	Neurology	Allergies
Endocrinology	Sleep				

Provider notes:

_____

_____

_____

_____

_____