

**OTOLARYNGOLOGY — HEAD AND NECK SURGERY
DAVID L. WITSELL, MD, MHS**

PATIENT RETURN VISIT FORM

Patient Name: _____ **Duke #:** _____ **Date:** _____

Reason for today's visit: _____

Since the last time you saw Dr. Witsell, have you been diagnosed with any **new medical problems**?

NO **YES** - - Please list

Since the last time you saw Dr. Witsell, have you developed any **new allergies**?

NO **YES** - - Please list

Since the last time you saw Dr. Witsell, 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.

<p>CONSTITUTIONAL: <input type="checkbox"/> NONE</p> <p><input type="checkbox"/> Weakness <input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight Gain</p> <p>Other: _____</p>	<p>SKIN <input type="checkbox"/> NONE</p> <p><input type="checkbox"/> Lumps <input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Lesions</p> <p>Other: _____</p>
<p>EYES: <input type="checkbox"/> NONE</p> <p><input type="checkbox"/> Itching <input type="checkbox"/> Excess Tearing <input type="checkbox"/> Change in Vision <input type="checkbox"/> Double Vision</p> <p>Other: _____</p>	<p>EARS: <input type="checkbox"/> NONE</p> <p><input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Discharge <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Ringing/Buzzing <input type="checkbox"/> Dizziness/Imbalance</p> <p>Other: _____</p>
<p>NOSE: <input type="checkbox"/> NONE</p> <p><input type="checkbox"/> Obstruction <input type="checkbox"/> Discharge <input type="checkbox"/> Bleeding <input type="checkbox"/> Loss of smell</p> <p>Other: _____</p>	<p>MOUTH/THROAT: <input type="checkbox"/> NONE</p> <p><input type="checkbox"/> Sores/Ulcers <input type="checkbox"/> Throat Pain <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Voice Changes</p> <p>Other: _____</p>
<p>NECK: <input type="checkbox"/> NONE</p> <p><input type="checkbox"/> Stiffness <input type="checkbox"/> Lumps/Swelling <input type="checkbox"/> Pain</p> <p>Other: _____</p>	<p>HEART/LUNGS: <input type="checkbox"/> NONE</p> <p><input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough</p> <p>Other: _____</p>
<p>DIGESTIVE/URINARY: <input type="checkbox"/> NONE</p> <p><input type="checkbox"/> Heartburn/Indigestion <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Burning with Urination <input type="checkbox"/> Urinary incontinence <input type="checkbox"/> Urinary retention</p> <p>Other: _____</p>	<p>NERVOUS/VASCULAR: <input type="checkbox"/> NONE</p> <p><input type="checkbox"/> Headache <input type="checkbox"/> Numbness <input type="checkbox"/> Tremor</p> <p>Other: _____</p>

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: _____