Bay Area Cardiology Associates, P.A.
Consultative, Diagnostic & Interventional Cardiology
FOLLOW-UP VISIT QUESTIONNAIRE

PATIENT NAME: ____ **DATE:** ___/_______/

DOB: ____/___/______ ***CURRENT PHONE #***: (___)_____- ___ ***E-Mail Address*** ***(optional)***

Please answer questionnaire so that we may update your file:
Since your last visit with us, are there any changes in your history:

(1) Did you change your Primary Care Physician ? IF YES Describe:

(2) Who is your local pharmacy ? Describe:
Who is your mail order pharmacy? Describe:

(3) Have you been hospitalized ? IF YES Describe:

(4) Do you have any new medical problems ? IF YES Describe:

(5) Have you had any new surgery ? IF YES Describe:

(6) Do you have any changes in medications ? IF YES Describe:

(7) Do you have any new allergies ? IF YES Describe:

(8) Any changes in marital status ? IF YES Describe:

(9) Have you had any changes in habit(s) i.e., (smoking, alcohol, drug use, etc.) IF YES Describe:

(10) Any family members with new cardiovascular problems ? IF YES Describe:

(11) Have you seen a specialist ? IF YES Describe:

(12) Do you have a Living Will ? ❐ YES ❐ NO

(13) Do you have Advanced Directives ? ❐ YES ❐ NO

(14) Do you have a HealthCare Surrogate(s) ? ❐ YES ❐ NO

(15) Do you need any medication refills today? **(If YES, list medications below)**

1) 4)

2) 5)

3) 6)

Patient Signature Physician Signature

OFFICE USE ONLY:

Medical Asst: **Room #**

Reason for Visit:

Protime Followed by BAC: ❒ YES ❒ NO ❒ N/A

Pacemaker Followed by BAC: ❒ YES ❒ NO ❒ N/A

EKG done by BAC: ❒ YES ❒ NO ❒ N/A

Notes: