Follow Up Questionnaire

Name:_____ **Date:**_____

Email:_____

Primary Care Physician(required):_____

Insurance Carrier(required):_____

Have any of our physicians ordered any of the following tests since your last visit:

Radiology testing Yes____ No____

If so at which location was the test performed?_____

Blood-work Yes____ No____

If so which lab performed the tests? _____

Reason for Todays visit:_____

_____

_____

Please list all physicians that you would like to receive your reports:

1. _____
2. _____
3. _____

Is it ok to leave a message? Yes_____ No_____
If so which phone number is the best number to use? _____

PLEASE REVIEW & CORRECT THE ATTACHED MEDICATION LIST.

Sleep Patients Only:

Do you have a CPAP card with you? Yes____ No____

Have you submitted your CPAP card to your DME company? Yes____ No____

Patient Signature_____

(For Office Use) BP_____ Pulse_____ Weight_____