Gayle S. Schwartz, MD & Associates, PA
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Follow-up Form

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: _____ Alternate #: _____

Email: _____

Do you have an Advance Care Plan or someone legally authorized to make health care decisions for you?

(Circle) Y or N (Please provide documentation if possible)

List **ALL MEDICATIONS AND DOSAGES** you currently take (include over the counter and supplements). **You MUST list, or provide a list, even if there is no change**:

_____
_____
_____
_____
_____

ALLERGIES (include latex): _____

NEW MEDICAL PROBLEMS since your last visit (hospitalizations, surgeries, etc.):

_____

_____

Date of Last: COVID-19 Vaccine _____ Flu Shot _____ Pneumonia Vaccine _____

Tetanus Vaccine_____ Shingles Vaccine_____

Have you ever smoked? Y or N Quit date? _____ How much do you currently smoke? _____

How often and in what quantity do you consume alcohol?_____

Doctors you would like us to send your notes to (include their specialty):

_____

Who should be billed for today's visit? Medical insurance, auto accident or injury at work. Please include any primary or secondary insurance, and also please mention if this is related to an auto accident or injury at work:

_____

Signature _____ Date_____