Monterey Bay G.I. Consultants Medical Group, Inc.
Monterey Bay Endoscopy Center

PATIENT FOLLOW-UP QUESTIONNAIRE

(To be filled out at every returning visit, less than one year)

Patient Name: ____ Date: ________________

Primary Care MD:__________________ Referring MD:___________________

Current Medications: ____

____

(Please list all or attach a list of your current medications)

New problems since last visit: ____

____

____

REVIEW OF SYSTEMS:

(Please circle yes or no)

Headaches	Yes	No
Blurry Vision	Yes	No
Chest Pain	Yes	No
Cough	Yes	No
Shortness of Breath	Yes	No
Pain on Urination	Yes	No
Rash	Yes	No
Joint Pain	Yes	No
Depression	Yes	No
Fever or Chills	Yes	No
Excessive Urination	Yes	No

or Thirst	Yes	No