# Gregory H. Tchejeyan, M.D.

Follow Up Patient Information

Please fill out this form in its entirety. Please complete every line item, as it is necessitated by regulations from the government (Health Care Finance Administration – HCFA)

**Please darken all bubbles completely!!**

**Patient Name:**_____ **Date:**_____
**DOB:** _____

I. Which side is affected? O Right O Left O Bilateral

II. Joint or part(s) that you are being seen for today: _____

III. Since you were last seen:

How is your pain? O Better O Unchanged O Worse

How is your motion? O Better O Unchanged O Worse

Did you return to work? O Yes O No O Never stopped

IV. Have you had any new (*since your last visit*) problems with:

A. Trouble with numbness or tingling? O Yes O No

B. Have you had a stroke? O Yes O No

C. Trouble with your heart? O Yes O No

D. Trouble with your breathing? O Yes O No

E. Trouble with your bowels? O Yes O No

F. Trouble with your bladder? O Yes O No

Have you started any new medications? O Yes O No

If yes, please list medication_____

Signature: _____ Date: _____