



Johns Hopkins  
 Bayview  
 Medical Center  
**CARDIOLOGY  
 CLINIC**



**PHYSICIAN UPDATE for RETURN VISIT**

Please take a moment to update us since your last visit. Thank you.

**CURRENT MEDICATIONS: Please update or provide a list to physician.**

NAME	DOSE	TIMES/DAY	NAME	DOSE	TIMES/DAY
1			8		
2			9		
3			10		
4			11		
5			12		
6			13		
7			14		

**\*\* Do you need heart medication refills?       YES       NO**

**Please list recent doctor visits, hospitalizations, surgery, tests, or new diagnosis.**

**Please check new or ongoing problems:**

- |   |   |
|---|---|
| <input type="checkbox"/> Chest Pain or discomfort     | <input type="checkbox"/> Shortness of Breath          |
| <input type="checkbox"/> Weakness or Fatigue          | <input type="checkbox"/> Swelling in the feet or legs |
| <input type="checkbox"/> Weight Gain or Loss          | <input type="checkbox"/> Palpitations                 |
| <input type="checkbox"/> Dizziness or Lightheadedness | <input type="checkbox"/> Fainting or Black Out        |
| <input type="checkbox"/> Bleeding (anywhere)          | <input type="checkbox"/> Bruising easily              |
| <input type="checkbox"/> Blood clots                  |   |
| <input type="checkbox"/> Other: _____                 |   |

**Please circle level of pain in general or since last visit:**



**Requirement for JCAHO regulation:**

- Does anyone hurt you or someone else in your family?       Yes       No**  
**Are you (or anybody in the family) afraid?       Yes       No**