Geetha M. Reddy, M.D. F.A.C.C.

Name:_____**Date of Birth**:_____**Primary Doctor**:_____

Have you had any of the following pertaining to this visit today? Circle Yes or No

Chest Pain	Yes / No	Cold, Clammy Sweats	Yes / No		
Palpitations	Yes / No	Passing Out	Yes / No	Waking at night	Yes / No
Pain in Calves	Yes / No	Swelling in Feet	Yes / No		
with Walking					
Weight Gain	Yes / No	Weight Loss	Yes / No	Fever	Yes / No
Visual Changes	Yes / No	Hearing Loss	Yes / No		
Snoring	Yes / No	Coughing blood	Yes / No	Shortness of Breath	Yes / No
Nausea	Yes / No	Acid Reflux	Yes / No	Blood In Stool	Yes / No
Blood In Urine	Yes / No	Urination at night	Yes / No		
Dizziness	Yes / No	Memory Loss	Yes / No	Seizures	Yes / No
Depression	Yes / No	Hallucinations	Yes / No		
Rash	Yes / No	Skin Sores	Yes / No		
		Tremors	Yes / No		
Joint pain	Yes / No	Muscle Aches	Yes / No		

Have you received the Covid Vaccine _____

Have you been hospitalized since your last visit? If so Dates and Where?

_____

Name of pharmacy for medications and refills_____

1880 W. Winchester Rd., Ste 207
Libertyville, IL – 60048

15 Tower Ct, Ste 210
Gurnee, IL 60031

3021 Falling Waters Blvd , Ste C
Lindenhurst, IL 60046

Phone (847) 816-3703 Fax (847) 816-4534