

Patient Name _____

Date _____

Date of Birth _____

Phone _____

Primary Doctor

Name: _____

Address: _____

City, ST ZIP: _____

Phone #: _____

Fax #: _____

Pharmacy

Name: _____

Address: _____

City, ST ZIP: _____

Phone #: _____

Fax #: _____

Describe New Problem (if applicable) in 10 Words or Less:

What Brings You to the Doctor Today?

- Regularly scheduled follow-up for same thing as last time
- Regularly scheduled follow-up, new problem
- Follow-up visit after doctor saw me in the hospital
- Go over test results
- Returning sooner than planned
- Haven't been here in a while
- Urgent problem that developed very recently

Misc. Personal Information:

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Any recent change in where you live, or whom you live with? |
| <input type="checkbox"/> | <input type="checkbox"/> | Any recent change in your work duties (retirement, new job, disability, etc)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Any recent change in how much you smoke or drink? |

Update on Other Medical Problems:

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you spent any nights in a hospital since your last visit? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been to the ER since your last visit? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you seen your primary doctor since your last visit? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did any of your doctors change any of your medications since your last visit? |

Patient Name _____

DOB _____

Please check Yes or No

Constitutional

- Yes No Fatigue
- Fevers
- Trouble *getting* to sleep
- Trouble *staying* asleep
- Weight gain
- Weight loss

Eyes

- Yes No Blurred vision
- Double vision
- Loss of vision

Ears, Nose, Mouth, and Throat

- Yes No Loss of sense of smell
- Hearing loss
- Ringing in your ears

Cardiovascular and Respiratory

- Yes No Chest pain
- Palpitations
- Shortness of breath

Gastrointestinal

- Yes No Constipation
- Diarrhea
- Heartburn
- Nausea
- Vomiting

Bladder & Sexual Function (Genitourinary)

- Yes No Loss of bladder control
- Loss of desire for sex
- Menopause (women)
- Trouble with erection (men)
- Urgency to urinate

Skin

- Yes No Change in hair or nails
- Change in skin color
- Itching
- Rash

Neurological

- Yes No Confusion
- Falling down
- Headaches
- Incoordination
- Involuntary movements or jerking
- Lightheaded or dizzy
- Loss of consciousness/fainting/passing out
- Numbness
- Seizure or convulsion
- Spinning or vertigo
- Swallowing problems
- Tingling
- Tremor
- Trouble speaking
- Trouble walking
- Weakness

Musculoskeletal

- Yes No Back pain
- Joint pain or swelling
- Muscle pain or cramps
- Neck pain

Endocrine

- Yes No Heat or cold intolerance
- Increased thirst
- Loss of hair

Memory, Thinking, Mood, Psychiatric

- Yes No Anxiety
- Depressed mood
- Hallucinations (seeing or hearing things)
- Memory loss

Hematologic (blood) and lymphatic

- Yes No Anemia
- Easy bruising or bleeding
- Slow to heal after cuts

Allergic and Immune

- Yes No Allergic reaction to medicine or x-ray dye



Signature of patient

Date

Signature of person completing form
(if not patient)

Date

Patient Name _____ DOB _____

Returning Patient Medication List

Please bring to your appointment and list below any medications you have **STARTED TAKING** since your last visit.

▶ Include over-the-counter medications, dietary supplements, etc.

	NAME	DOSE	FREQUENCY	REASON	SINCE
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					

Please list below any medications you have **STOPPED TAKING** since your last visit

	NAME	DOSE	FREQUENCY	REASON	SINCE
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					



Important

To assist us in providing the best patient care, please **bring** all of your medications with you to every visit with your physician.

We need to keep an accurate record of the medicines you are **currently** taking.