TODAY'S VISIT FORM

Welcome to our office – thank you for trusting us with your care!

Please complete this form to make your appointment today as helpful as possible. There is space on the back of this form to write your list of medicines if you did not bring a list with you.

What are the main concerns you would like to talk to your doctor about today?

1. _____
2. _____
3. _____

Have you recently:

- □ Had labs or tests done at another doctor's office?
- □ Had an x-ray, CT scan, MRI, or other imaging study done?
- □ Been to a specialist?
- □ Been to urgent care or the emergency room?
- □ Been admitted to the hospital?

Please indicate where and on what date these services occurred:

_____
_____
_____
_____
_____

Are you experiencing any of the following symptoms (new or worsening)?

- □ Black/Tarry Stools
- □ Bleeding
- □ Blood in Stool
- □ Breathing Difficulty
- □ Bruising (unusual)
- □ Chest Pain or Tightness
- □ Cough
- □ Coughing Blood
- □ Disorganized Thinking
- □ Excessive Thirst
- □ Eye Pain
- □ Falls
- □ Fatigue (new or worsening)
- □ Feeling Anxious
- □ Feeling Down
- □ Fever
- □ Headaches (new or worsening)
- □ Hearing Loss (new or worsening)
- □ Heartbeat Concerns
- □ Memory Problems
- □ Numbness
- □ Sexual Concerns
- □ Skin Changes (recent)
- □ Stomach Pain
- □ Swallowing Problem
- □ Swollen Ankles
- □ Urination Change
- □ Vision Change (recent)
- □ Watery Stools
- □ Weakness
- □ Weight Change (unintentional)
- □ Wheezing
- □ Other:_____

- □ Pain (new or worsening)
  Location:_____
  Severity from 0-10:_____

Female Patients Only:

- □ Breast Changes
- □ Menstrual or Vaginal Bleeding Concerns
  Last Menstrual Period_____

Follow-up plan (Your care team will add any follow-up items at the end of the visit.)

_____
_____
_____

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Thank you for completing this form. Your care team will review the information you provided and talk with you about the most important issues to cover at today's visit.

If you did not bring a medicine list with you today, please list all medicines you are currently taking below. This includes prescription medicines, over-the-counter (OTC) medicines, vitamins, and supplements.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

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