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 ☐ Sexual Concerns
☐ Bleeding ☐ Skin Changes (recent)
☐ Blood in Stool ☐ Stomach Pain
☐ Breathing Difficulty ☐ Swallowing Problem
☐ Bruising (unusual) ☐ Swollen Ankles
☐ Chest Pain or Tightness ☐ Urination Change
☐ Cough ☐ Vision Change (recent)
☐ Coughing Blood ☐ Watery Stools
☐ Disorganized Thinking ☐ Weakness
☐ Excessive Thirst ☐ Weight Change (unintentional)
☐ Eye Pain ☐ Wheezing
☐ Falls ☐ Other:____________________
☐ Fatigue (new or worsening) ☐ Pain (new or worsening)
☐ Feeling Anxious Location:____________________
☐ Feeling Down Severity from 0-10:_______
☐ Fever Female Patients Only:
☐ Headaches (new or worsening) ☐ Breast Changes
☐ Hearing Loss (new or worsening) ☐ Menstrual or Vaginal Bleeding Concerns
☐ Heartbeat Concerns Last Menstrual Period__________
☐ Memory Problems ☐ Numbness
☐ Numbness

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

__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________
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. __________________________________________________________________________________________