

DATE:	NAME:	DATE OF BIRTH:
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Welcome! Please list the reason(s) or goals for today's visit. READING THE FOLLOWING AND FILLING OUT THE RIGHT FORMS **HELPS US STAY ON TIME**. HELP HER HELP EVERYONE IN A FAIR AND RESPECTFUL MANNER. IF EVERYONE SURPRISES HER WITH UNEXPECTED REQUESTS WE ALL SUFFER!

- WELLNESS?** WRITE THAT IN **box #1 AND REQUEST A PURPLE SHEET from Front Desk. But you also must leave #2 and #3 blank. It's wellness or problem oriented, it can't be both. Note Medicare wellness can't include labs or physical exam starting 1/2019.**
- NEW INJURY OR PAIN? **REQUEST A GREEN SHEET FROM FRONT DESK.** LIST THE INJURY OR PAIN UNDER THE GOALS BELOW.
- NEW TESTING OUTSIDE OF OFFICE, X-RAYS, **CONSULTATIONS YOU WANT TO DISCUSS WITH Provider. MUST INFORM Front Desk OR WHOEVER ROOMS YOU. IF MENTIONED FIRST TO Provider WILL NEED TO RETURN TO DISCUSS.**

CONCERNS AND GOALS FOR TODAY'S VISIT

1	
2	
3	

Please list any medications needing to be refilled **within the next 90 days**, indicate WHERE to send, local pharmacy or mail order. When you request at appointment instead of relying on pharmacy or Jessica you free up Jessica's time to work on prior auth's, answer questions and schedule testing. BE RESPONSIBLE. Know your meds. YOU SHOULD CARRY A LIST OF YOUR MEDICATIONS ON YOUR PERSON AT ALL TIMES!

MEDICATION REFILLS

1	<input type="checkbox"/> PHARMACY <input type="checkbox"/> MAIL ORDER
2	<input type="checkbox"/> PHARMACY <input type="checkbox"/> MAIL ORDER
3	<input type="checkbox"/> PHARMACY <input type="checkbox"/> MAIL ORDER

The following questions (below and on the back of the page) are to review symptoms you are experiencing currently or in past 6 months. Please circle any current symptoms TWICE. It is important that you go through each category even if it does not seem to apply to the purpose of your visit.

Check this box if no change in your REVIEW OF SYMPTOMS since last visit

GENERAL Fever | Chills | Sweats | Appetite Loss | Fatigue | Sleepiness | Sleep Problems | Recent Weight Gain | Recent Weight Loss | Not Satisfied with Weight

STOMACH/INTESTINAL Constipation | Diarrhea | Vomiting | Nausea | Heartburn | Abdominal Pain | Change in Bowel Habits | Black Tar-Like Stool | Blood in Stool | Yellowing of skin

EYES Eye Pain | Vision Loss | Excessive Tears | Sensitive to Light | Itching | Blurring | Double Vision | Dryness | Discharge

GENITOURINARY Frequent Urination | Leakage | Burning | Itching | Foul Odor | Genital Sores | Sexually Active | Inability to orgasm | Prefer Male | Prefer Female | History of Sexual Abuse | Decreased Libido | New Sex Partner within Last 12 months | **Genitourinary Female Specific** Vaginal Discharge | Abnml Bleeding | Dryness | Painful intercourse | Frequent UTIs | **Genitourinary Male Specific** Difficulty Achieving Erection vs Keeping Erection | Lump in Scrotum | Dribbling | Difficulty Starting Urination

EAR/ NOSE/ THROAT Earache | Discharge | Ringing | Excess Wax | Hearing Loss | Nasal Congestion | Bleeding | Sinus or Nose Trouble | Sinus Drainage down Throat | Sore Throat | Hoarse | Lost voice | Trouble Swallowing | Swollen glands | Stiff neck

MUSCLES/BONES Back Pain | Joint Pain | Joint Swelling | Muscle Cramps | Muscle Weakness | Stiffness

HEART Chest Pain | Heart racing | Fainting | Unable to Lay Flat | Swollen Legs | Difficulty Breathing at Night | Difficulty of Breathing Under Exertion | Onset of Chest Pain with Activity vs At Rest

SKIN Rash | Itching | Ulcers or Growths | Excessive Scarring | Acne | Lumps | Bleeding Problems | Dryness | Lesion that won't heal

LUNGS Wheezing | Labored Breathing | Frequent sighing | Dry Coughing | Excessive mucus when coughing | Coughing Up Blood | Productive Coughing | Pain with inspiration

PLEASE CONTINUE ON THE BACK

EMOTIONAL/COMPREHENSION Anxiety | Depression | Insomnia
 Memory Loss | Thoughts or Attempts of Suicide | Anxiety
 | Hallucination | Paranoia | Mental Disturbance

NERVOUS SYSTEM Headaches | Fainting | Seizures | Weakness
 Numbness-Tingling | Transient Paralysis | Vertigo | Tremors

BLOOD/LYMPHATIC/BREASTS Abnormal Bruising | Bleeding
 Enlarged Lymph Nodes | History of Anemia | Lower Leg Swelling
 Arm Swelling | Breast Lumps or Tenderness
 Drainage from Nipple | Monthly Breast Exams? (Y N)

HORMONAL Excessive Thirst | Excessive Eating | Excessive
 Urination | Cold Intolerance | Heat Intolerance | Hair Loss | Hot
 Flashes or Night Sweats |
Female Specific Heavier-Lighter-Irregular-Absent Period | Uterine-
 Cervical-Vaginal-Ovarian Problems | Decrease in Tolerance or
 Results of Exercise | Seeking Pregnancy within the next 12 months
 (if so, are you on Prenatal Vitamins? Y N)

IMMUNE SYSTEM Hives | Hay Fever | Lyme or tick exposure | Mold
 exposure | Frequent Infections | HIV Exposure

PERSONAL SAFETY Do you feel safe in your home? Y N | Anyone
 trying to control you? Y N | Have you been hit, kicked, punched, or
 threatened by a partner or ex-partner? Y N

EXERCISE WHAT TYPE, HOW OFTEN, HOW LONG
 Describe your aerobic/cardio exercise habits:
 Describe your strength training exercise habits:

HEALTH SCREENING (if done elsewhere, ex mammograms not done here). Circle any of the following tests, procedures or educational materials you have been given within the last year and tell when:
 Colonoscopy | Cologuard | Mammogram | PAP | Prostate Exam | PSA
 Fasting Blood Sugar | Cholesterol | Thyroid Hormone | Bone Density
 Electrocardiogram (ECG) | Stress Test | Lung CT scan (smokers or ex)
 Pneumonia Vaccine | Shingles Vaccine | Tetanus or TDaP
 Flu Shot | Smoking Assessment & Cessation Education
Diabetic Specific: Eye Exam | Foot Exam | Urine Dip | At Least Two
 Lab Draws | Exercise Counseling | Dietary Education
 Want to participate in our upcoming Diabetic Education? Y N

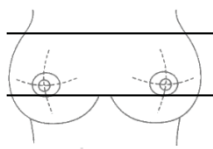
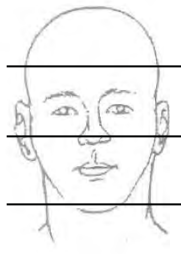
SOCIAL
 Describe Recent life changes: _____

 Are you satisfied with current living arrangement? Y N
 Are you satisfied with your current employment? Y N
 Do you feel you have adequate income? Y N

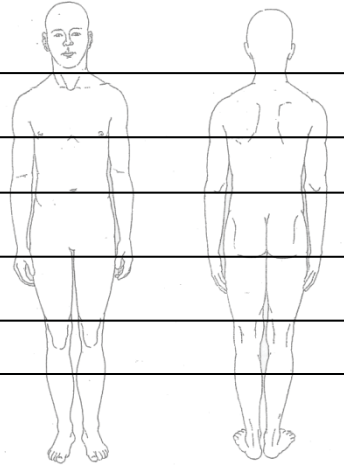
FOR OFFICE USE ONLY

BP: _____ (Cuff Size) P: _____ R: _____ T: _____ Ht: _____
 Wt: _____ LMP: _____ Last Mammo: _____ Last Pap: _____
 Gyne: _____ Colorectal: _____
 Smoker? Y N New Family or Social Hx? _____

O: General: _____
 Skin: _____
 HEENT: _____
 Neck: _____
 Cardiac: _____
 Lungs: _____
 Breasts: _____
 Abd: _____



Back: _____
 Pelvic: _____
 Rectal: _____
 Ext: _____
 Musculoskeletal: _____
 Neuro: _____
 Mental Status _____
 Assessment: _____ Plan: _____
 1.) _____ 1.) _____
 2.) _____ 2.) _____
 3.) _____ 3.) _____
 4.) _____ 4.) _____



Disposition Entered IN PRAXIS
 Disposition Written on Exit Sheet

PLEASE ADD CIRCLED INFO TO NOTE IN PRAXIS
 PLEASE ADD CODING 99214 99215 99204 99205 99203 99213

Add 'l Labs if possible today:
 JB to arrange (waiting for appt or she will call):