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**

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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

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

**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

**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

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

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

**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 | Abnormal Bleeding | Dryness | Painful intercourse | Frequent UTIs | Genitourinary Male Specific Difficulty Achieving Erection vs Keeping Erection | Lump in Scrotum | Dribbling | Difficulty Starting Urination

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

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

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)

BLOOD|

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 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

HORMONAL Specific  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

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:

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

DISPOSITION ENTERED IN PRAXIS

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):