

Name: _____ Date: _____

Reason for today's visit: _____

Since your last visit, has your insurance changed? Yes _____ No _____ *If yes, please be sure to give your new ID card to our receptionist so we can make a copy.

Since your last visit, has your address or phone number changed? Yes _____ No _____ *If yes, please provide: _____

If you are here to see a doctor or physician assistant, please answer the following questions. Otherwise, please return this form to the Reception Desk.

Since your last visit, have you experienced any of the following:

Please circle:

Comments:

Fevers, sweats, or weight loss	NO	Yes	
Loss of appetite	NO	Yes	
Hair loss	NO	Yes	
Nausea or vomiting	NO	Yes	
Visual problems	NO	Yes	
Headaches	NO	Yes	
Mouth sores, earaches, or sore throat	NO	Yes	
Chest pain	NO	Yes	
Cough	NO	Yes	
Breathing problems	NO	Yes	
Constipation	NO	Yes	
Diarrhea	NO	Yes	
Swelling	NO	Yes	
Rash	NO	Yes	
Problems with urination	NO	Yes	
Weakness (specify where)	NO	Yes	
Numbness or tingling	NO	Yes	
Bone pain (specify where)	NO	Yes	
Other pain (specify where)	NO	Yes	
Fatigue	NO	Yes	
Depression or anxiety	NO	Yes	
(Women) Problems with Menstruation or discontinuation of Menstruation	NO	Yes	
Other problems	NO	Yes	

Allergies:

Current Medications:

To be completed by nursing staff:

Weight: _____ Temp: _____ Pulse: _____ Blood Pressure: _____ / _____ O2 Sat _____ %

Comments:

RN/MA

MD