THIS FORM MUST BE COMPLETED BY THE PATIENT BEFORE SEEING THE DOCTOR

PATIENT'S NAME ________________________________ DATE OF BIRTH ________________ DATE ____________

REASON FOR TODAY'S VISIT (CC):

Check all applicable items: ❑ **Need Refills** ❑ **Sneezing** ❑ **Runny Nose** ❑ **Itchy Eyes** ❑ **Cough** ❑ **Wheeze**

❑ **Asthma** ❑ **Respiratory Infection** ❑ **Sinusitis** ❑ **Headache** ❑ **Fever** ❑ **Earache** ❑ **Discolored Discharge**

NEW PROBLEMS SINCE LAST VISIT: ____

REVIEW OF SYSTEMS: Are there any changes since your last visit? Please check.

___**Constitutional (weight loss, etc.)**
___**Allergy/Immunology**
___**Eyes**
___**Ears, Nose, Mouth, Throat**
___**Respiratory**
___**Cardiovascular**
___**Psychological**
___**Gastrointestinal**
___**Genitourinary**
___**Musculoskeletal**
___**Skin**
___**Neurological**
___**Endocrine**
___**Hematologie/Lymphatic**

PREVIOUS PROBLEMS: STABLE ________ OR WORSENING (describe) ______________________________________

LIST ALL MEDICATIONS AND THE DOSE PRESCRIBED TO YOU BY ALL PHYSICIANS WHICH YOU TAKE
NOTE: WE CAN ONLY REFILL MEDICATIONS PRESCRIBED TO YOU BY US.

MEDICATION	DOSE	TIMES TAKEN IN A DAY	REFILLS (if needed) 30 day supply	REFILLS (if needed) 90 day supply
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

ANY ALLERGIES TO MEDICATIONS ____

For Medical Staff Only: BP________**P**________**R** ________**TEMP**________**HT**________**WT**________**BMI**________**PF**________