

Visit Agenda

Patient: _____ **Date of Birth:** _____ **Today's Date:** _____

Thank you for taking the time to fill out this questionnaire. Please hand the completed questionnaire to the medical assistant when you are called back for your appointment and we will review together.

1. What is the main concern you would like us to focus on today?

2. If there is enough time available today, what other concern(s) would you like to discuss?

3. Please select all that apply for your visit today:

- | | |
|--|---|
| <input type="checkbox"/> Medication Refill _____ | <input type="checkbox"/> Specialist follow up _____ |
| <input type="checkbox"/> Lab Results _____ | <input type="checkbox"/> X-ray results _____ |
| <input type="checkbox"/> Referrals _____ | <input type="checkbox"/> Other _____ |

4. Have you had any of the following since your last visit? Please include facility and date.

- | | |
|---|--|
| <input type="checkbox"/> Hospital Admission _____ | <input type="checkbox"/> Colonoscopy _____ |
| <input type="checkbox"/> ER/Urgent Care Visit _____ | <input type="checkbox"/> PAP _____ |
| <input type="checkbox"/> Mammogram _____ | <input type="checkbox"/> Other (please list) _____ |

5. Please select one of the following:

- | | |
|---|---|
| <input type="checkbox"/> No falls in the past year | <input type="checkbox"/> 2 or more falls in the past year |
| <input type="checkbox"/> 1 fall without injury in the past year | <input type="checkbox"/> At least one fall with injury in the past year |

6. Have you used any tobacco products within the last 12 months? Yes | No

7. During the past month:

- Have you often been bothered by feeling down, depressed, or hopeless? Yes | No
- Have you often been bothered by little interest or pleasure in doing things? Yes | No

DOCTOR USE ONLY for Plan of Care

Preventative Care: Mammo, PAP, Colon, FIT, DM eye/foot, Immun: _____, Other: _____

Follow-up Appt: _____ Weeks/Months | 15 30 | CPE · DM · HTN · BP-MA · AHA · MedChk · _____ dx DM|HTN

Labs: Physical | DM annual | DM 3-6mo | See Note | Additional: _____

Info on **Eating Habits** [Yes No n/a] Info on **Exercise** [Yes No n/a]

HMO referrals: A letter will arrive in the mail 3 weeks from your appointment date.

Urgent referral: Handled within 3-5 days. If you don't hear from our office, please give us all.

