

VISIT PREPARATION CHECKLIST

Please answer the questions on both sides.



Name: _____ Date: _____

Today's visit is for: _____

If we have time, I'd also like to discuss: _____

I have had the following tests done already: (X-rays, lab tests) _____

The following treatments have been tried: _____

REVIEW OF SYMPTOMS: Please mark the symptoms you've been having recently.			
<p>GENERAL</p> <input type="checkbox"/> weight gain <input type="checkbox"/> weight loss <input type="checkbox"/> loss of appetite <input type="checkbox"/> fever <input type="checkbox"/> weakness <input type="checkbox"/> night sweats <input type="checkbox"/> dry mouth <input type="checkbox"/> depression <input type="checkbox"/> anxiety	<p>RESPIRATORY</p> <input type="checkbox"/> shortness of breath <input type="checkbox"/> chest tightness <input type="checkbox"/> cough <input type="checkbox"/> wheezing	<p>CARDIOLOGY</p> <input type="checkbox"/> chest pain <input type="checkbox"/> palpitations <input type="checkbox"/> leg swelling <input type="checkbox"/> shortness of breath	<p>NEUROLOGY</p> <input type="checkbox"/> headache <input type="checkbox"/> tingling/numbness <input type="checkbox"/> seizures <input type="checkbox"/> memory loss <input type="checkbox"/> problems walking <input type="checkbox"/> tremors/shaking
<p>SKIN</p> <input type="checkbox"/> rash <input type="checkbox"/> dry/sensitive skin <input type="checkbox"/> hives <input type="checkbox"/> new/worrisome moles <input type="checkbox"/> jaundice <input type="checkbox"/> redness <input type="checkbox"/> swelling <input type="checkbox"/> itching <input type="checkbox"/> bruising	<p>ALLERGY</p> <input type="checkbox"/> runny nose <input type="checkbox"/> scratchy throat <input type="checkbox"/> itchy eyes <input type="checkbox"/> ear fullness <input type="checkbox"/> sinus congestion <input type="checkbox"/> sneezing	<p>GASTROENTEROLOGY</p> <input type="checkbox"/> nausea <input type="checkbox"/> heartburn <input type="checkbox"/> history of having colon polyps <input type="checkbox"/> black tarry BM <input type="checkbox"/> vomiting <input type="checkbox"/> abdominal pain <input type="checkbox"/> diarrhea	<p>BLOOD/LYMPH</p> <input type="checkbox"/> swollen glands <input type="checkbox"/> fatigue <input type="checkbox"/> loss of appetite <input type="checkbox"/> easy bruising
<p>EYES</p> <input type="checkbox"/> decreased vision <input type="checkbox"/> eye drainage <input type="checkbox"/> blurry vision <input type="checkbox"/> eye itching <input type="checkbox"/> Glaucoma	<p>EAR/NOSE/THROAT</p> <input type="checkbox"/> congestion <input type="checkbox"/> cough <input type="checkbox"/> coughing blood <input type="checkbox"/> nosebleed <input type="checkbox"/> hearing loss <input type="checkbox"/> dizziness <input type="checkbox"/> ringing in ears <input type="checkbox"/> change in voice <input type="checkbox"/> sore throat <input type="checkbox"/> snoring <input type="checkbox"/> ear pain <input type="checkbox"/> ear drainage <input type="checkbox"/> swollen tonsils <input type="checkbox"/> difficulty swallowing	<p>MUSCULOSKELETAL</p> <input type="checkbox"/> joint stiffness <input type="checkbox"/> leg cramps <input type="checkbox"/> joint pain <input type="checkbox"/> joint swelling <input type="checkbox"/> back pain <input type="checkbox"/> neck pain <input type="checkbox"/> jaw pain	<p>ENDOCRINE</p> <input type="checkbox"/> fatigue <input type="checkbox"/> excessive sweating <input type="checkbox"/> excessive thirst <input type="checkbox"/> excessive urination <input type="checkbox"/> sleep problems <input type="checkbox"/> heat intolerance <input type="checkbox"/> cold intolerance <input type="checkbox"/> lump in neck or thyroid

Medications / Medical History

NONE OF THE FOLLOWING INFORMATION HAS CHANGED SINCE MY LAST VISIT TO THIS OFFICE (IF NOTHING HAS CHANGED, YOU DON'T HAVE TO FILL OUT THE REST OF THE FORM.)

CURRENT MEDICATIONS (INCLUDE VITAMINS, SUPPLEMENTS, AND OVER THE COUNTER MEDS)	
1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

MEDICAL HISTORY / CURRENT MEDICAL PROBLEMS (CHECK ALL THAT APPLY, FILL IN ANY OTHERS)

- High Blood Pressure
- Diabetes
- Heart Problems: _____
- Damaged Heart Valves: _____
- High Cholesterol
- Asthma
- Infections/TB/Hepatitis/HIV _____
- _____

- Emphysema/Bronchitis
- Thyroid Problems: _____
- Stomach/GI/Reflux: _____
- Cancer, type: _____
- Sleep Apnea: _____
- Kidney: _____
- _____
- _____

MEDICATION ALLERGIES

NAME OF MEDICATION	TYPE OF REACTION
	<input type="checkbox"/> rash <input type="checkbox"/> difficulty breathing <input type="checkbox"/> stomach pain/vomiting <input type="checkbox"/> other: _____
	<input type="checkbox"/> rash <input type="checkbox"/> difficulty breathing <input type="checkbox"/> stomach pain/vomiting <input type="checkbox"/> other: _____
	<input type="checkbox"/> rash <input type="checkbox"/> difficulty breathing <input type="checkbox"/> stomach pain/vomiting <input type="checkbox"/> other: _____
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	<input type="checkbox"/> rash <input type="checkbox"/> difficulty breathing <input type="checkbox"/> stomach pain/vomiting <input type="checkbox"/> other: _____

SURGERIES

TYPE OF SURGERY	SURGEON	HOSPITAL	DATE

HOSPITALIZATIONS (DO NOT INCLUDE SURGERIES LISTED ABOVE)

REASON	DOCTOR	HOSPITAL	DATE

FAMILY MEDICAL HISTORY (PLEASE ADD ANY OTHERS NOT LISTED)

Conditions/Problems	Family Members affected and exact nature of problems
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart Problems	
<input type="checkbox"/> Cancer	
<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> Malignant Hyperthermia	
<input type="checkbox"/> Hearing Loss Before Age 60	
<input type="checkbox"/> Bleeding/Clotting Disorder	

SOCIAL HISTORY / HABITS

- Smoker: _____ packs/day Non-smoker Quit smoking in _____
- Smokeless Tobacco: _____
- I exercise regularly I exercise rarely I do not exercise
- Alcohol use: Yes (drinks/week: _____) No
- I have traveled outside the United States in the past three months

Thank You