"Respectful, Evidence-based, Collaborative Care"

BAPTIST Primary Care

www.baptistprimarycare.net

University South
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TODAY'S VISIT

Name: _____. **Date:** _____.

Reason for visit/problem?:

_____.

Complete 1-5 if this appointment was scheduled to evaluate a new problem

1. When did it start? _____.

2. How often does it occur? (Daily, weekly, etc.) _____.

3. How long does it last? (Minutes, hours, constant.) _____.

4. Quality of discomfort? (dull, achy, sharp, etc.) _____.

5. Pain Level (circle): **1-3** (Mild). **4-6** (Moderate). **7-8** (Severe). **9** (Crying). **10** (Extreme).

Do you Smoke? Yes☐ No☐ **If yes, how much?**_____.

If you still smoke, are you interested in quitting? Yes☐ No☐

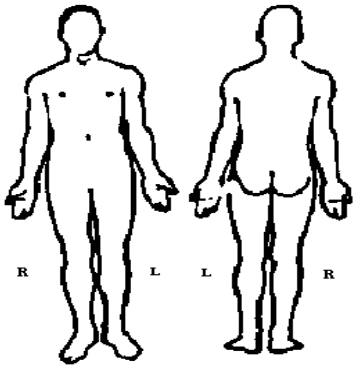
Do you have more than 7 drinks (beer, wine, liquor) **a week?** Yes☐ No☐

If Yes, do you drink more than 14 a week? Yes☐ No☐

Name of anyone here with you._____.

Any medication changes since we last saw you? Yes☐ No☐

Medication refills needed? Yes☐ No☐



Shade your area of pain above

Trigger:

_____

_____

Relief:

_____

_____

Review of Systems: Please CHECK ALL BOXES Yes or No. CIRCLE any that are new or worsening.

Fever?	Yes☐ No☐	**Irregular heartbeats?**	Yes☐ No☐	**Night Sweats?**	Yes☐ No☐
Excessive fatigue?	Yes☐ No☐	**Black out episodes?**	Yes☐ No☐	**Low interest in sex?**	Yes☐ No☐
Abnormal weight loss?	Yes☐ No☐	**Swelling in feet?**	Yes☐ No☐	**Abnormally cold?**	Yes☐ No☐
Headache?	Yes☐ No☐	**Heartburn?**	Yes☐ No☐	**Dark/irregular moles?**	Yes☐ No☐
Eye issues?	Yes☐ No☐	**Nausea?**	Yes☐ No☐	**Rash?**	Yes☐ No☐
Nasal congestion?	Yes☐ No☐	**Diarrhea?**	Yes☐ No☐	**Breast mass/pain?**	Yes☐ No☐
Sore throat?	Yes☐ No☐	**Constipation?**	Yes☐ No☐	**Numbness/Tingling?**	Yes☐ No☐
Cough?	Yes☐ No☐	**Black or bloody BM's?**	Yes☐ No☐	**Memory problems?**	Yes☐ No☐
Wheezing?	Yes☐ No☐	**Urinary problems?**	Yes☐ No☐	**Are you Depressed?**	Yes☐ No☐
Shortness of Breath?	Yes☐ No☐	**Blood in Urine?**	Yes☐ No☐	**Excessive Anxiety?**	Yes☐ No☐
Stop breathing at night?	Yes☐ No☐	**Abnormal joint pain?**	Yes☐ No☐	**Trouble sleeping?**	Yes☐ No☐
Chest discomfort?	Yes☐ No☐	**Abnormal muscle pain?**	Yes☐ No☐	**Abnormal bruising?**	Yes☐ No☐

Expand on new symptoms or add anything?

_____