PATIENT AGENDA

Please take a moment to answer the questions below to best use the time spent today with your provider.

Name: _____ DOB: _____ Date: _____

1. **What concerns do you want to discuss at today's appointment?**

   _____

   _____

2. **What symptoms do you want your provider to be aware?**

3. _____

   _____

4. **What providers (hospital, Emergency Room, Urgent Care Clinic, Specialist, etc.) have you seen since your last visit or hospital stay?**

5. _____

   _____

6. **What questions do you have for your provider?**

   _____

   _____

   _____

7. **Do you have specific requests for any of the following?** (be specific)

   - New/refilled medications _____

     _____

   - Tests/Referrals _____

     _____

   - Completion of forms _____
   - Work/School Forms _____
   - Other _____

8. **Have you traveled outside the United States in the last 21 days?** (circle) Yes No

If so, please specify: Guinea, Libera, Nigeria, Senegal, Sierra Leone Other: _____

9. **Often, we will have medical/nursing/physician's assistant students in office. Do you have any objection to having a student present during your visit?** (circle)

   Yes No

Patient Name: _____ DOB: _____

Please mark "Y" for **yes** or "N" for **no** if you recently have any of the following:

Constitutional:

☐ **Y** ☐ **N** Fever

☐ **Y** ☐ **N** Fatigue (tiredness)

☐ **Y** ☐ **N** Recent (unintentional)Weight Loss (____ lbs)

☐ **Y** ☐ **N** Recent Weight Gain (____ lbs)

☐ **Y** ☐ **N** Not feeling well

☐ **Y** ☐ **N** Chills

Dermatologic:

☐ **Y** ☐ **N** Rash Ulcer

☐ **Y** ☐ **N** Ulcer

HEENT:

☐ **Y** ☐ **N** Vision changes

☐ **Y** ☐ **N** Hearing loss

☐ **Y** ☐ **N** Nasal drainage

Respiratory:

☐ **Y** ☐ **N** Acute Cough

☐ **Y** ☐ **N** Shortness of breath

☐ **Y** ☐ **N** Wheezing

Cardiovascular:

☐ **Y** ☐ **N** Chest Pain

☐ **Y** ☐ **N** Palpitations

☐ **Y** ☐ **N** Edema (swelling)

Gastrointestinal:

☐ **Y** ☐ **N** Abdominal Pain

☐ **Y** ☐ **N** Blood in Stools

☐ **Y** ☐ **N** Constipation

☐ **Y** ☐ **N** Diarrhea

☐ **Y** ☐ **N** Heartburn

☐ **Y** ☐ **N** Nausea

☐ **Y** ☐ **N** Vomiting

Genitourinary:

☐ **Y** ☐ **N** Polyuria (excessive urine output)

☐ **Y** ☐ **N** Urinary frequency

☐ **Y** ☐ **N** Urinary incontinence (loss of control)

Reproductive:

☐ **Y** ☐ **N** Breast lump

☐ **Y** ☐ **N** Breast pain

☐ **Y** ☐ **N** Nipple pain

Metabolic/Endocrine:

☐ **Y** ☐ **N** Cold intolerance

☐ **Y** ☐ **N** Heat intolerance

Neurological:

☐ **Y** ☐ **N** Headache

☐ **Y** ☐ **N** Memory impairment

☐ **Y** ☐ **N** Dizziness

☐ **Y** ☐ **N** Seizures

☐ **Y** ☐ **N** Extremity numbness

☐ **Y** ☐ **N** Extremity weakness

Psychiatric:

☐ **Y** ☐ **N** Anxiety

☐ **Y** ☐ **N** Depression

☐ **Y** ☐ **N** Insomnia

Integumentary:

☐ **Y** ☐ **N** Hair loss

☐ **Y** ☐ **N** Hives

☐ **Y** ☐ **N** Rash

☐ **Y** ☐ **N** Skin lesion

☐ **Y** ☐ **N** Pruritis (itching)

Musculoskeletal:

☐ **Y** ☐ **N** Back pain

☐ **Y** ☐ **N** Joint pain

☐ **Y** ☐ **N** Joint swelling

☐ **Y** ☐ **N** Muscle weakness

☐ **Y** ☐ **N** Neck pain

_____

(Patient signature)

_____

(Today's date)