Do not write, stamp, punch holes or affix a sticker in this area.
To reproduce, follow the printing instructions. Fold only on the dotted lines.

Today's Visit

Please answer every question

Direction of Feed

STAFF: *Handwritten items must be entered* ***MANUALLY***.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

REASON FOR VISIT

ALLERGIES **Please list all items you are allergic to:**

○ **I have NO known MEDICATION allergies**

please fold on dotted line

Please indicate if you have had these symptoms within the PAST MONTH.

Mark all that apply. If you have no symptoms in a category, please mark "NONE".

○ **I have had NO changes in my health status since my last visit.**

GENERAL
- unexpected weight loss (>10 lbs) ○
- fever ○
- headache ○
- difficulty sleeping ○
- **NONE** ○

HEENT
- vision changes ○
- pain or redness of eyes ○
- nosebleeds ○
- mouth sores ○
- **NONE** ○

RESPIRATORY
- shortness of breath ○
- **NONE** ○

GENITOURINARY
- frequent urination ○
- **NONE** ○

SKIN
- skin rash ○
- **NONE** ○

NEUROLOGIC
- loss of memory ○
- dizziness / lightheadedness ○
- **NONE** ○

MUSCULOSKELETAL
- aching joints ○
- **NONE** ○

please fold on dotted line

CARDIOVASCULAR
- chest pain ○
- shortness of breath ○
- **NONE** ○

GASTROINTESTINAL
- heartburn ○
- nausea ○
- vomiting ○
- diarrhea ○
- constipation ○
- rectal bleeding ○
- yellow eyes ○
- black or tarry stools ○
- difficulty swallowing ○
- change in bowel habits ○
- abdominal pain ○
  - **location of abdominal pain:**
  - upper ○
  - lower ○
  - right ○
  - left ○
- **NONE** ○

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SAMPLE

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