**PATIENT NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **TODAY’S DATE:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

==================================================================================================

**Primary Care Provider (Name/Clinic):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Can we send a letter back to your primary/referring provider(s)?** ☐ **YES** ☐ **NO**

**What are your primary goals for this visit/questions you have for your doctor?**

☐ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PLEASE CHECK THE SYMPTOMS YOU ARE CURRENTLY/VERY RECENTLY EXPERIENCING:**

**GENERAL: EYES: EARS/NOSE/SINUSES/THROAT:**

☐ Fatigue ☐ Itchy ☐ Stuffy nose ☐ Poor sense of smell

☐ Fever ☐ Watery ☐ Runny nose ☐ Nosebleeds

☐ Difficulty sleeping ☐ Red ☐ Sneezing ☐ Ear pain/fullness

☐ Anxiety ☐ Puffy ☐ Itchy nose ☐ Snoring

☐ Depression ☐ Vision changes ☐ Post-nasal drainage ☐ Sore throat

☐ Facial pressure ☐ Itchy throat

**LUNGS: HEART/BLOOD VESSELS: GI TRACT: SKIN:**

☐ Chest tightness ☐ Chest pain ☐ Stomach pain ☐ Eczema

☐ Cough ☐ High blood pressure ☐ Diarrhea ☐ Hives

☐ Shortness of breath ☐ Irregular heartbeat ☐ Difficulty swallowing ☐ Itching

☐ Sputum/phlegm ☐ Swelling in hands/feet ☐ Heartburn ☐ Swelling

☐ Wheezing ☐ Color changes of skin ☐ Weight loss

**MUSCLES/BONES: ENDOCRINE: BLOOD: NERVOUS SYSTEM:**

☐ Joint pain ☐ Dry mouth ☐ Swollen glands/nodes ☐ Dizziness

☐ Joint redness ☐ Cold intolerance ☐ Anemia ☐ Headache

☐ Joint swelling ☐ Hot flashes ☐ Easy bruising ☐ Pain

 ☐ Tingling/numbness

**LOCAL PHARMACY: MAIL-ORDER PHARMACY:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cross-streets:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_