# How can we help you today?

**Page 1: Completed by the patient and given to the doctor**

Your name: _____     Today's date: _____

1. What are your health questions for today's visit? Please list in order of importance to you.




2. Are you are experiencing pain today? ☐ Yes   ☐ No

   If yes, please rate your pain level on a scale of 1 to 10, with 10 being highest: _____

3. Please check the option below that best describes your emotional health today.

   ☐ Positive (calm, happy)   ☐ Neutral (bored, passive)   ☐ Negative (downhearted, distressed)

   Would you like to discuss your emotional health with the doctor today? ☐ Yes   ☐ No

Since your last visit:

4. Have you experienced any important changes in your health? ☐ Yes   ☐ No

5. Have you seen any other physicians or been admitted to the hospital? ☐ Yes   ☐ No

6. Have you had a fall or any trouble with balance? ☐ Yes   ☐ No

7. Has bladder control been a problem? ☐ Yes   ☐ No

8. Have you been engaging in weekly physical activity? ☐ Yes   ☐ No

9. Have you had any tests, screenings or vaccines that this office may not be aware of?
   ☐ Yes   ☐ No

10. Have you started any new prescriptions and/or over-the-counter medications?
    ☐ Yes   ☐ No

    If yes, please list them here:




11. Are you experiencing side effects from any current prescriptions and/or over-the-counter medications? ☐ Yes   ☐ No

12. When you have medical tests, do you know how to get your test results? ☐ Yes   ☐ No

13. Do you have an up-to-date advance directive on file with us? ☐ Yes   ☐ No   ☐ Don't know

# Medical appointment summary

| | |
|---|---|
| Doctor's name: | Today's date: |
| My blood pressure today: | My body mass index (BMI) today: |

| **Topics we discussed today:** | **Notes:** |
|---|---|
| ☐ Bladder control<br>☐ Emotional well-being<br>☐ Exercise (plan/prescription)<br>☐ Fall prevention<br>☐ General health changes<br>☐ Medications<br>☐ Pain management<br>☐ Test results<br>☐ Other: _____<br><br>_____<br><br>_____<br><br>_____ | |

| **Procedures needed:** | **Notes:** |
|---|---|
| ☐ Bone density test<br>☐ Colorectal screening<br>☐ Eye exam (diabetic/regular)<br>☐ Flu vaccine<br>☐ Labs<br>☐ Mammography<br>☐ Other: _____<br><br>_____<br><br>_____<br><br>_____ | |

How to get my test results:


Next appointment date: