BAPTIST Primary Care

**University South**
Charles H. Booras, MD, FAAFP
Richard Bowles, MD
Shelby Augustin, APRN

# Acute or Follow Up Office Visit

## Patient Information

Patient name ______________________________ Date ______________

Reason for visit ______________________________________________

______________________________________________________________

*(Unscheduled issues, concerns or form completions may require a separate appointment.)*

Since last visit I have had ❏ Labs ❏ X-ray ❏ ER visit ❏ Acute care visit ❏ Specialist consult ❏ Other testing

Medication refills needed? ❏ Yes ❏ No | Prefer ❏ 30-day or ❏ 90-day refills?
*(Notify staff of pharmacy change).*

Any medication changes since last appointment? ❏ Yes ❏ No ____________________

Any new conditions diagnosed? ❏ Yes ❏ No ______________________________

Any changes in your family history? ❏ Yes ❏ No ___________________________

Nicotine use? ❏ Yes ❏ No If yes, how much? ______________________________

If you smoke, or use any form of tobacco, are you interested in quitting? ❏ Yes ❏ No

Alcohol use? ❏ None ❏ Less than 7 drinks a week ❏ 7-14 drinks a week ❏ More than 14 a week

Name of anyone in the exam room with you ________________________________

Relation? ____________________________________________________

Are you interested in scheduling a prevention oriented "physical" (wellness visit)? ❏ Yes ❏ No

## Review of Systems

*Please* ***check** all boxes for current symptoms* *and* ***circle** any new/worsening symptoms* *that you would like to have evaluated further (may require additional testing and appointment).*

| | | |
|---|---|---|
| ❏ Fever (documented) | ❏ Irregular heartbeats | ❏ Muscle pain |
| ❏ Excessive fatigue | ❏ Chest pain/pressure | ❏ Joint pain |
| ❏ Abnormal weight change | ❏ Swelling in feet | ❏ Rash |
| ❏ Headache | ❏ Heartburn | ❏ Breast mass or pain |
| ❏ Eye issues | ❏ Nausea or vomiting | ❏ Numbness/tingling |
| ❏ Nasal congestion | ❏ Diarrhea | ❏ Memory problems |
| ❏ Sore throat | ❏ Black or bloody BM's | ❏ Sad, hopeless |
| ❏ Cough | ❏ Urinary problems | ❏ Loss of interest |
| ❏ Wheezing | ❏ Cold intolerance | ❏ Excessive anxiety |
| ❏ Shortness of breath | ❏ Abnormally low sex drive | ❏ Trouble sleeping |
| ❏ Stop breathing at night | ❏ Abnormal bruising | ❏ Other (list below) |

Other symptoms of concern? ______________________________________