Visit Overview

Please note that this form will be used for composing the visit note, but will not become part of the medical record. It will be destroyed after the visit.

Patient Name _____ **DOB:** _____ **Today's Date:** _____

Medicine or Food Allergies _____

Current Medications _____

Main reason for today's visit (chief complaint): _____

When did the problem/symptoms begin? _____

In the last 14 days, has the patient TESTED POSITIVE for COVID-19? □ **Yes** □ **No**

In the last 14 days, has the patient been EXPOSED to anyone with CONFIRMED or SUSPECTED COVID-19? □ **Yes** □ **No**

Please circle an answer for each question (if applicable):

What is the location?	Left side	Right Side	Both Sides	Not Applicable	
What is the pattern?	Continuous	Intermittent	Chronic	Acute	Not Applicable
How severe are the symptoms?		Mild	Moderate	Severe	
What are the symptoms like?	Worsening	Improving	Unchanged	Sharp pain	Dull pain

Has the patient had any of the following symptoms **during this illness?** Check Y or N for each symptom

□ **Y**	□ **N**	Fever	□ **Y**	□ **N**	Vomiting
□ **Y**	□ **N**	Aches	□ **Y**	□ **N**	Diarrhea
□ **Y**	□ **N**	Red eyes or eye discharge	□ **Y**	□ **N**	Abdominal Pain
□ **Y**	□ **N**	Runny or stuffy nose	□ **Y**	□ **N**	Frequent urination
□ **Y**	□ **N**	Sore throat	□ **Y**	□ **N**	Pain with urination
□ **Y**	□ **N**	Ear pain	□ **Y**	□ **N**	Blood in the urine
□ **Y**	□ **N**	Daytime cough	□ **Y**	□ **N**	Joint pain
□ **Y**	□ **N**	Wheezing or difficulty breathing	□ **Y**	□ **N**	Rash
□ **Y**	□ **N**	Chest pain	□ **Y**	□ **N**	Headaches

Patient's past medical history that is important for today: _____

Does anyone in the household smoke or use electronic cigarettes inside or outside the home? □ **Yes** □ **No**

For females, when did your last menstrual period start? _____

Which pharmacy would you like to use if a prescription is to be sent electronically? _____

Have there been any changes to your insurance or contact information since your last visit? □ **Yes** □ **No**

The medical directors and/or providers regularly pray for patients who visit the practice. Would you like them to pray for you/your child when they are praying for patients? □ **Yes** □ **No**