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Patient Agenda Form

Name _____Date _____

Please take a moment to answer the questions below in order to best use the time spent today with your provider.

1. What do you want to discuss/have done at today's appointment?

_____

2. What symptoms do you want your provider to be aware of?

_____

3. What providers (hospital, ER, Urgent Care , Specialist, etc.) have you seen since your last visit?

_____

4. Please list <u>all</u> your medications (including OTC, vitamins and supplements, we prescribe or any other provider, please indicating any changes or any new medicines)

Drug Name	Dose	how often taken?	Refill needed? (30 or 90 days)

5. ***<u>Please circle below</u>***

Do you drink alcoholic beverages? Yes No

Do you use recreational drugs? example (Marijuana/Cocaine/Heroin etc.) Yes No

Do you smoke cigarettes or us tobacco? Yes No

6. Please list all allergies:_____

7. Do you have specific requests for:
   - New medications/Tests/Referrals/Completion of forms/Work or School Forms

_____