

INTERVAL OFFICE EVALUATION NOTE

(PATIENT TO FILL OUT BEFORE PHYSICIAN PORTION OF VISIT)

Date: _____ Name: _____

Are there any questions you wished answered for this visit? Y or N

If so list: _____

List your current medications (including Over-The-Counter medications):

(Name)	(Dose)	(Frequency)	(Refill needed?)	Pharmacy
_____	_____	_____	Y or N	Mail Order: Y or N Local: Y or N
_____	_____	_____	Y or N	
_____	_____	_____	Y or N	
_____	_____	_____	Y or N	
_____	_____	_____	Y or N	
_____	_____	_____	Y or N	
_____	_____	_____	Y or N	
_____	_____	_____	Y or N	

Since your last visit have you seen another physician or other health care provider? Y or N

If yes, list: _____

(name)	(date)	(condition)
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Has there been any interval changes in your family history or social situation since you were last seen (e.g., new diagnoses in family members, divorce, job change, etc)? Y or N

If yes, describe: _____

Do you currently have any of the following symptoms or conditions? (circle only if positive)

Abdominal Pain	Anemia or Bruising	Arthritis or Joint Pain	Change in Bowel Habits
Cancer	Chest Pain	Shortness of Breath	Convulsion or Seizure
Diarrhea/Constipation	Headaches/Migraine	Leg Pain with Exercise	Nervousness or Depression
Numbness or Tingling	Blood in Stool	Stroke or Coordination	Urination Difficulties
Change in Vision	Weight Loss	Nosebleeds	Foot Sores or Skin Lesions
Dizziness or Fainting	Foot Pain	Jaundice or Yellowing	Thyroid Disease

Women only, please answer the following questions:

Pregnancy	Planning Pregnancy	Menstrual Irregularities
B.C. Method: _____	Last Pap: _____	Last Mammogram: _____
Breast Discharge	Flushing	Hot Flashes