

RETURN VISIT

Date: _____ Age: _____ Date of Birth: _____
 Name: _____ Occupation: _____
 Email Address: _____ Spouse/Partner's Name: _____
 REASON FOR VISIT: (please circle): Annual Visit Problem (Description) _____
 Pharmacy Phone: _____ Primary Care Doctor: _____

CURRENT MEDICATIONS

Drug Name	Dosage	Prescribed by	Drug name	Dosage	Prescribed by
ALLERGIES TO MEDICATIONS/SUBSTANCES			LIST:		
List all natural or herbal remedies over-the-counter drugs, vitamins, minerals you are taking			LIST:		

PAST MEDICAL/FAMILY HISTORY UPDATE

CHANGES? YES ___ List: NO ___	Tobacco Use Alcohol Use Family History of blood clots? Contraceptive Choice? N/A	yes ___ yes ___ yes ___ N/A	no ___ no ___ no ___ _____
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SURGERY/HOSPITALIZATION UPDATE No Changes ___

Procedure	Date	Procedure	Date	Procedure	Date

GYNECOLOGIC UPDATE

Date of last period?	How many days between periods?	Do you pass clots? Yes No
How many days does period last?	Flow: Light Medium Heavy	Bleeding between periods? Yes No

REVIEW OF SYMPTOMS (Please mark all that apply)

Symptoms	Yes	Symptoms	Yes	Symptoms	Yes
Constitutional		Respiratory		Musculoskeletal	
Fatigue		Cough		Joint pain	
Fever		Shortness of breath		Muscle pain	
Weight Loss		Wheezing		Muscle weakness	
Weight Gain		Coughing up Blood		Endocrine	
Other:		Gastrointestinal		Heat/cold intolerance	
Eyes, Ears, Nose & Throat		Nausea/vomiting		Hair loss	
Impaired Vision		Constipation		Hot flashes	
Vision Change		Blood in stool		Night sweats	
Headache		Diarrhea		Psychiatric	
Sore Throat		Genitourinary		Anxiety	
Lightheadedness		Urgency to urinate		Depression or frequent crying	
Sinusitis		Frequency of urination		Difficulty sleeping	
Ulcers		Painful urination		Hematologic	
Breast		Blood in urine		Easy bruising	
Lumps		Incomplete emptying of bladder		Bleed easily	
Tenderness		Incontinence		Enlarged lymph glands	
Swelling		Skin		Blood transfusions	
Nipple Discharge		Rash			
Cardiovascular		Moles (new growth or changes)			
Chest Pain		Neurologic			
Irregular heart beat		Numbness			
		Memory Difficulties			
		Seizures			

FORM COMPLETED BY: ___ Patient ___ OFFICE NURSE ___ PHYSICIAN ___ OTHER _____

Signature of Patient: _____ Signature of Physician _____

Patient Contact Information

Patient Name: _____

Social Security Number: _____

Please check one of the following boxes:

I do not wish to make any changes to the individual(s) I previously listed as having permission to access my protected information. **OR**

Any physician, staff, employee, or representative of Sparks & Favor PC has my permission to discuss my account and medical conditions—which may include symptom, treatments, diagnosis, test results, medications or any other type of protected health information—with the following persons in order to facilitate and coordinate my care, treatment, and payment.

(name) (relationship) (phone)

(name) (relationship) (phone)

(name) (relationship) (phone)

(name) (relationship) (phone)

(name) (relationship) (phone)

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can withdraw this permission by signing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if this information is shared with the above individual(s) it may be subject to re-disclosure by the individual(s).

(Patient's Signature) (Date)

Note Regarding Annual Exams

A yearly exam without a co-pay does not apply to visits addressing problems or complaints (such as abnormal bleeding, menopausal symptoms, breast pain, etc.). For our patients' convenience, our physicians are very pleased to address any concern or problem you may have at the same time as your yearly exam. Please be aware, however, that an office visit will be submitted to your insurance company and a co-pay may be required.