SPARKS & FAVOR, P.C.

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 Name and 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 yes ____ no ____
Alcohol Use yes ____ no ____
Family History of blood clots? yes ____ no ____
Contraceptive Choice? N/A _____

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 _____

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Patient Contact Information

Patient Name: _____

Any physician, staff, employee, or representative of Sparks & Favor has my permission to discuss my account and medical conditions--which may include symptoms, 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.

☐ Check here if you choose NOT to allow access of your medical records to anyone.

_____	_____	_____
(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.