Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is the main reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Since your last visit, have you had any of the following?** Please explain any YES answers on the lines provided.

**1. ER Visit Y / N** -Name of ER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. XRay, Ultra Sound, MRI or Other Imaging Y / N**- Name of facility who did the imaging: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of Imaging was done? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on what part of your body? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Visit with a Specialty DR Y / N**-Name of DR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Have you started or stopped taking any medications or supplements? Y / N**

If Yes, Please list the medications and supplements and if you have started or stopped them: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Since your last visit have you had any changes in the following areas?** YES NO

1. Change in eating habits, weight loss, decreased energy, sleeping habits \_\_\_ \_\_\_

2. Eye pain, redness, increased tearing, drainage, blurred or decreased vision \_\_\_ \_\_\_

3. Ear pain, decreased hearing, nose, mouth, throat, sinus problems \_\_\_ \_\_\_

4. Heart problems, chest pain, increased blood pressure, leg swelling \_\_\_ \_\_\_

5. Lung problems, difficulty breathing, wheezing, infections \_\_\_ \_\_\_

6. Abdominal pain, vomiting, diarrhea, constipation, blood, etc. \_\_\_ \_\_\_

7. Kidney or bladder problems, infections, blood in urine \_\_\_ \_\_\_

8. Joint pain, stiffness, swelling, muscle pain, weakness \_\_\_ \_\_\_

9. Skin rashes, itching, dryness, hair or nail problems \_\_\_ \_\_\_

10. Recurrent headaches, dizziness, numbness, weakness \_\_\_ \_\_\_

11. Excessive thirst or hunger, increased urination, weight loss \_\_\_ \_\_\_

12. Paleness, anemia, easy bruising, swollen glands \_\_\_ \_\_\_

13. Allergies: food, hay fever, asthma, increased infections \_\_\_ \_\_\_

 Please List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14. Stress, anxiety, sadness, depression, suicidal thoughts \_\_\_ \_\_\_

15. Feeling little interest or pleasure in doing things \_\_\_ \_\_\_

**Please explain any yes answers from the questions 1-12 above:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1 Timothy 2:1 tells us that “supplications, prayers, intercessions, and thanksgivings should be made for all people”.

 In our weekly staff meetings, we like to pray for our patients. If there is anything you would like us to pray for or a praise that we can thank God for in your life, please write it on the back of this page.