Ask-My-Doctor Form

Appointment Date: _____My Visit Today is With: _____

Do You Have Any New Symptoms Since Your Last Visit? YES or NO

Reason for Visit: _____

Since Your Last Visit with Us, Have You Seen/Been to Any Hospitals / Urgent Care / ER / Doctors:

Doctor's Name	Specialty / Reason

Please List Your Medications, Supplements, and Dosages (Including Over the Counter Medications):

Medications or Supplements	Dosages	Frequency

YES – I Have Additional Medication Please List on the Back of this sheet

Are You Current with Your Preventative Health Screens? (Circle YES or NO**)**

Yes or No - **Vision Check**	**Annually**
Yes or No - **Cholesterol, LDL, HDL, High A1C**	**Annually**
Yes or No - **Depression**	**Annually**
Yes or No - **Flu Vaccination**	**Annually**
Yes or No - **Pelvic/PAP**	**Every 1 to 3 years**
Yes or No - **Shingles**	**Once Every 8 Years (Age 65 or Over)**
Yes or No - **Pneumonia Vaccination**	**Once Every 8 Years (Age 65 or Over)**
Yes or No - **Carotid Ultrasound**	**Per your physician**
Yes or No - **Colonoscopy**	**Per your physician**
Yes or No – **Osteoporosis**	**Per your physician**
Yes or No - **Prostate (men) or Mammogram (women)**	**Per your physician**

Optional Questions (Circle YES or NO)

Has Your Mood Changed? YES or NO
Are You Worried About Your Memory? YES or NO
Do You Worry About Falling? YES or NO
Did you receive a Flu-Shot this year? YES or NO

Do You Have (Circle YES or NO):

Living Will: YES or NO **Health Care Surrogate:** YES or NO **Durable Power of Attorney:** YES or NO