WOODS FAMILY MEDICINE

ABBEY L. WOODS, MD

TODAY'S VISIT INFORMATION:

Patient's Name: _____ Date of Birth: _____

Reason for today's visit: _____

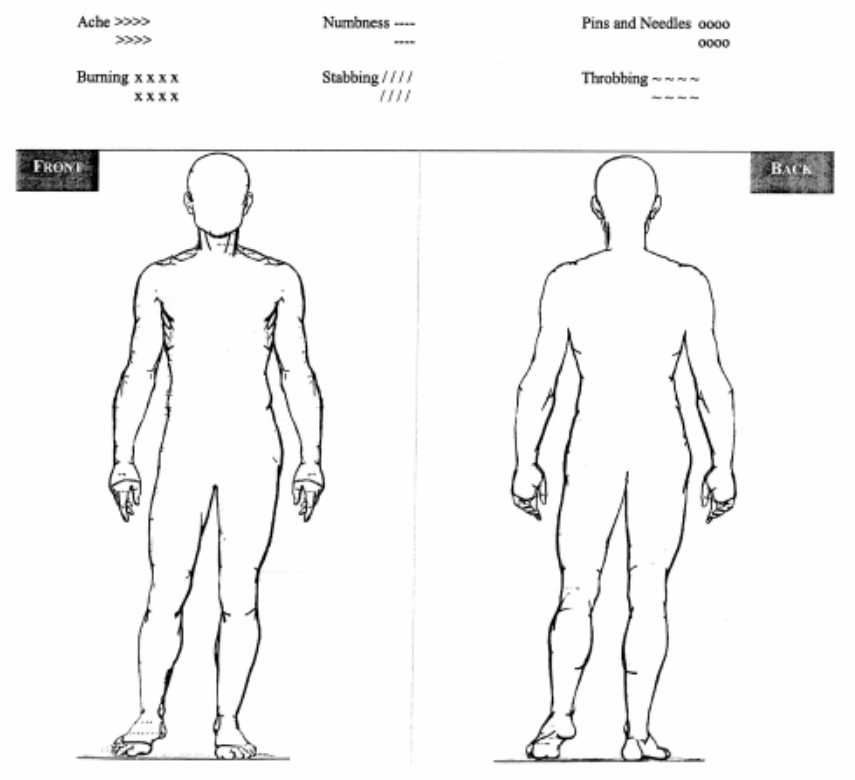
Any new medications since last visit? NO/ YES (explain) _____

Any specialist visit, ER, or hospitalization since last visit: NO/ YES (explain) _____

Any falls since last visit? NO/YES _____

Review of Systems:			
Over the last two weeks have you had any of the following: (circle)			
☐ Headache	☐ Blurry or double vision	☐ Nasal discharge/bleeding	☐ Trouble swallowing
☐ Lumps or bumps in neck	☐ Hoarseness	☐ Ear pain	☐ Ringing in ears
☐ Cough	☐ Chest pain	☐ Shortness of breath	☐ Palpitations (heart racing)
☐ Stomach pain	☐ Change in bowel habits	☐ Blood in urine or stool	☐ Numbness or tingling in hands or feet
☐ Fever	☐ Weakness	☐ Dizziness	☐ Leg swelling

Any pain today? NO/ YES
Where?



Do you need any medications refilled?
NO/ YES _____
_____
_____

Will you need a note for work or school?
NO/ YES _____