Patient Agenda Form

Date_______________

Name ________________________ **Phone No.** ___________________ **E-mail** ____________________

Vital Signs BP ______/______ **Pulse**_________ **Temp**________ **Resp** _______ **Pulse Ox** _____%

Weight__________ **Height**___________ **Pain** ____/10 (1-10)

Please take a moment to answer the questions below in order to best use the time spent today with your provider.

Do you have TNCare ☐ **Medicare** ☐ **Insurance** ☐

Do you smoke? Y☐ **N** ☐ **How much alcohol do you drink? Never**☐ **Occasional** ☐ **Daily** ☐

1. What concerns do you want to be sure to discuss at today's appointment?

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2. What symptoms do you want your provider to be aware of?

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3. What providers (hospital, Emergency Room, Urgent Care Clinic, Specialist, etc.) have you seen since your last visit? ____

4. Please list all your medications (including OTC, vitamins and supplements). Indicate any changes or any new medicines.

Drug Name	Strength	Times taken per day	**Refill (30 or 90 days)**

5. Please list all allergies: ______________________________ Latex? Yes☐ No ☐

6. Do you have specific requests?
   - Prayer (for you or family) ____________________________
   - New Medication ____________________________
   - Test/Referrals ____________________________
   - Completion of forms ____________________________

CBC CMP BMP A1c BS LIPID LIVER THY TESTOST PSA Pap U/A C&S Other ________________

Cort/Depo Referral____________________ Test_____________________________

PAPS ____