# Patient Pre-Visit Checklist

Patient's name (first & last) | DOB | Today's date

Person completing this form: ☐ Self ☐ Family member ☐ Friend ☐ Other (specify):

**What are your top two health concerns you want your doctor to know about:**

- _____
- _____

**Please answer all the questions on this form as best you can and discuss any questions you have with your doctor.**

## Care received since your last PCP visit

| | | |
|---|---|---|
| 1. Did you see any specialists since your last PCP Visit? | No ☐ | Yes ☐ |
| 2. Do you need any help coordinating the care you are receiving from other doctors? | No ☐ | Yes ☐ |
| 3. Do you have any questions about labs, x-rays, or other tests results? | No ☐ | Yes ☐ |
| 4. Were you recently in the hospital or seen in the Emergency Room? | No ☐ | Yes ☐ |
| 5. Do you have questions about where to go when you need urgent care? | No ☐ | Yes ☐ |

## Your medications

| | | |
|---|---|---|
| 6. Do you have any questions or issues with any of the medications you are taking? | No ☐ | Yes ☐ |
| 7. Are you having any issues getting your medications prescribed or filled? | No ☐ | Yes ☐ |

## Your safety and wellbeing

| | | |
|---|---|---|
| 8. Do you get your annual flu shot? | Yes ☐ | No ☐ |
| 9. Have you had any falls or problems with balance or walking? | No ☐ | Yes ☐ |
| 10. Do you have concerns about bladder control or are you experiencing issues with leaking of urine? | No ☐ | Yes ☐ |
| 11. Do you often feel sad, worried or have difficulty sleeping, or remembering things? | No ☐ | Yes ☐ |
| 12. Do your emotions or mental health limit you in your work or daily activities? | No ☐ | Yes ☐ |

## Your physical health

| | | |
|---|---|---|
| 13. Do you need any help eating, bathing, dressing, walking, or using the bathroom? | No ☐ | Yes ☐ |
| 14. Do you have any difficulties that limit your ability to complete daily activities? | No ☐ | Yes ☐ |
| 15. Are you interested in starting, changing, or maintaining an exercise routine? | No ☐ | Yes ☐ |

**Clinic use only**

Reviewed by: _____ on ___/___/___ Reported to (Physician/Provider): _____