



**Today I will need a:**

- School/Work Excuse
- Medication Refill
- New Referral
- Form Completed

**Has your pharmacy changed:**  Yes  No

**If yes please provide the following information:**

Pharmacy Name and \_\_\_\_\_

Address \_\_\_\_\_

**What brings you in today?**

- Routine (follow-up or chronic care)
- Well (Physical or screening)
- Sick (active symptoms/new problem)\*

**\*If sick, please list symptoms or questions you would like to discuss during your visit:**

**(Circle the most important to you)**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. If you were to choose one thing to improve in your health this month, what would it be?  
\_\_\_\_\_

<b>Are you currently experiencing the following symptoms?</b>		
<b>General</b>	Fever, chills, weight loss or fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>ENT</b>	Nasal congestion or sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Eyes</b>	Change in vision or blurred vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Lungs</b>	Cough, shortness of breath or difficulty breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Heart</b>	Chest pain or palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>GI</b>	Nausea, vomiting, change in bowel habits	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Urologic/ Gynecologic</b>	Painful urination or urinary frequency	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have penile or vaginal discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Any breast pain, lump or discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
	Have you had recent changes with your menstrual period?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
	What was the date of your last menstrual period?	_____
<b>Neurological</b>	Numbness, tingling, weakness, or headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Endocrine/ Diabetes</b>	Do you monitor your blood sugar?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If so, are they running less than 120 before meals?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Preventive Care</b>	Have you been hit, kicked, punched or otherwise hurt by someone within the past year? If so by whom? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you feel safe in your current relationship?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is there a partner from a previous relationship who if making you feel unsafe now?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you had a preventive visit in the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Skin</b>	Are there any changes in your skin (rash or moles)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Musculoskeletal</b>	Do you have any joint pain or swelling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Depression Screening</b>	During the past month, have you felt down, depressed or hopeless	<input type="checkbox"/> Yes <input type="checkbox"/> No
	During the past month, have you felt little interest or pleasure	<input type="checkbox"/> Yes <input type="checkbox"/> No