LIST ANY PROVIDERS THAT YOU ARE CURRENTLY SEEING AS A PATIENT. USE REVERSE SIDE FOR MORE SPACE.

| Name | Type of Provider | Date Last Seen |
| --- | --- | --- |
| | | |
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## SINCE YOUR LAST WELL VISIT

1. HAVE YOU BEEN DIAGNOSED WITH ANY NEW MEDICAL PROBLEMS SUCH AS GLAUCOMA, HEART DISEASE, CATARACTS, ETC

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______________________________

2. HAD ANY MEDICAL PROCEDURES OR SURGERIES SUCH AS PAP SMEAR, COLONOSCOPY, CATARACT SURGERY, ETC

______________________________

______________________________

3. HAD ANY IMAGING STUDIES SUCH AS MRI, ULTRASOUND, CORONARY CALCIUM SCORE, ETC

______________________________

______________________________

4. TRAVELED OUTSIDE THE UNITED STATES YES/NO

Where/when______________________________

5. BEEN EXPOSED TO TB (tuberculosis) YES/NO

Where/when______________________________

LIST ALL CURRENT MEDICATIONS INCLUDING HERBAL AND OVER-THE-COUNTER AND BRING BOTTLES WITH YOU. USE REVERSE SIDE FOR MORE SPACE.

| Name | How Much/How Often |
| --- | --- |
| | |
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| | |

DO YOU HAVE ANY NEW MEDICAL CONDITIONS OR CONCERNS THAT YOU WANT TO DISCUSS AT YOUR WELL-VISIT APPOINTMENT:

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