View Patient Template

[redacted]

Items marked with **are required.

[redacted]

[redacted]

Respiratory Complaints

You should seek medical help immediately, if you are coughing and have shortness of breath, are working hard to breathe or have trouble talking or walking.

General History
Thank you for answering the following questions to the best of your ability.

General language and communication:
Preferred contact methods:
I understand that the [redacted] will contact me to inform me of lab/diagnostic testing results, important messages, appointment reminders, and other information.

I understand that sensitive medical information such as lab results and personalized health information will be communicated directly in person, by phone, or via a secure message. Secure messages can only be accessed through the [redacted] Portal.

I request that for other messages, reminders and general information that are not considered sensitive medical information, I would prefer to be contacted by:

- ○ Phone call
- ○ Text message
- ○ Voicemail message
- ○ Secure message
- ○ Letter

Language

☐ English is my preferred language for discussing health care.

My preferred language for discussing health care is: _____

Communication Needs

Please identify any aids you require for effective communication:

☐ Sign Language Interpreter ☐ Plain Language Media Materials ☐ Verbal Language Translator

☐ Hearing Aids ☐ Glasses ☐ Translated Media Materials

☐ Text Based Device

The [redacted] does not have interpreters on site. If you need a sign language interpreter for this visit, please allow 24 hours if possible so that we may arrange for this service with the Disability Resource Center or another interpreting service. Please contact your primary care clinic nurse or provider by secure message or email [redacted] to make this request and to confirm your needs.

Comment: _____

Safety

Do you feel safe at your current residence?

○ Yes ○ No

Please explain if you do not feel safe.

[redacted] [redacted]

We are able to electronically prescribe to the [redacted] pharmacy. Please help by choosing the option that best applies to you..

○I plan on getting my prescriptions at the [redacted] Pharmacy.

○I would get my medications at a different pharmacy.

○I am not certain where I would get my prescriptions filled.

If you are female, on what date did your last menstrual cycle begin?

Please share any past full time employment or current work you do in addition to your educational pursuits.

Do you smoke? ○Yes ○No

:If yes, please explain (cigarettes, cigar, pipe, vape, tobacco, other):

Do you drink alcohol? ○Yes ○No

Please describe your usual drinking habits:

Respiratory History

** How long have you been having symptoms (in days)?

** How long did it take to feel this bad?

○Less than a day

○1-2 days

○3 or more days

** Has someone you lived with been sick? ○Yes ○No

** In the past 24 hours, how much have you limited your activities due to illness?
(Normal activity level = 10 and completely confined to bed is 0)

○0 (Bed Ridden) ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10 (No Limit)

General/Systemic:

** Fever..... ○Yes ○No

** Chills and/or Sweats ○Yes ○No

** Headache..... ○Yes ○No

** Fatigue..... ○Yes ○No

** Can't Sleep..... ○Yes ○No

Nose, sinus and throat:

** Nasal Congestion..... ○Yes ○No

** Runny Nose..... ○Yes ○No

** Sneezing..... ○Yes ○No

** Face Pain or Toothache..... ○Yes ○No

** Sore Throat..... ○Yes ○No

** Swollen/Tender Lymph Nodes ○Yes ○No

Eyes and Ears:

** Ear Pain..... ○Yes ○No

** Loss of Hearing.... ○Yes ○No

** Eye Pain/Irritation.. ○Yes ○No

** Itchy, Watery Eyes.. ○Yes ○No

** Change of Vision.. ○Yes ○No

Chest:

** Cough..... ○Yes ○No

** Wheezing..... ○Yes ○No

** Shortness of Breath ○Yes ○No

** Chest pain..... ○Yes ○No

** Chest Congestion... ○Yes ○No

Abdomen:

** Nausea..... ○Yes ○No

** Vomiting..... ○Yes ○No

** Abdominal Pain.. ○Yes ○No

** Diarrhea..... ○Yes ○No

Please rank the intensity of the following (if they apply):

** Cough

○None ○Mild ○Moderate ○Severe

** Body or muscle aches.

○None ○Mild ○Moderate ○Severe

** Weakness

○None ○Mild ○Moderate ○Severe

** Have you had your flu shot this season [redacted]? ☐Yes ☐No

How has your illness evolved??

What measures have you tried to get or feel better?

Indicate below any other concerns that you have (please note that time constraints may force us to address these in a separate appointment).

Supplemental Information

Thanks for submitting your questionnaire.

[redacted]

DO NOT HIT CONTINUE MORE THAN ONCE OR ELSE DATA WILL BE LOST

Submit

[redacted]

[redacted]