PINNACLE
Family Health Care

Provider: Sasipha "Kate" Pahamark (Family Nurse Practitioner)
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Return Patient Sick Visit (Adult)

First Name: _____ **Middle Name:** _____ **Last Name:** _____

Date of Birth: _____ **Biological Sex:** ☐ **Male** ☐ **Female**

REASON FOR VISIT TODAY: _____

_____

Are you currently experiencing any of the following problems or symptoms?

- ☐ Fever or chills
- ☐ Poor Appetite
- ☐ Weight Loss
- ☐ Headaches
- ☐ Trouble swallowing
- ☐ Mouth Sores
- ☐ Runny Nose
- ☐ Snoring
- ☐ Decreased hearing/ringing in ears
- ☐ Ear Pain
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Chest pain
- ☐ Palpitations
- ☐ Swelling
- ☐ Nausea or vomiting
- ☐ Heartburn or indigestion
- ☐ Abdominal pain
- ☐ Diarrhea or constipation
- ☐ Blood in the stool or black stools
- ☐ Rectal pain
- ☐ Change in bowel movements
- ☐ Gas or belching
- ☐ Involuntary loss of urine
- ☐ Pain/burning with urination
- ☐ Blood in Urine
- ☐ Neck or back pain
- ☐ Pain, swelling, or stiffness in joints
- ☐ Muscle pain
- ☐ Dizziness
- ☐ Weakness
- ☐ Fainting
- ☐ Seizures
- ☐ Numbness or tingling
- ☐ Speech Difficulties
- ☐ Trouble Sleeping
- ☐ Feel tired all the time
- ☐ Feel nervous, tense, or stressed
- ☐ Feel depressed
- ☐ Increased thirst or urination
- ☐ Hot/Cold Intolerance
- ☐ Skin rashes
- ☐ Sneezing or itchy watery eyes

FEMALES ONLY:

- ☐ Discharge from breast
- ☐ Vaginal discharge/bleeding
- ☐ Pain with intercourse
- ☐ Loss of sexual desire

MALES ONLY:

- ☐ Testicular swelling or pain
- ☐ Loss of sexual function/desire
- ☐ Penile rash or discharge
- ☐ Pain with intercourse

1) Have you had any ER or Urgent Care visits since your last visit to our office? ☐ **Yes** ☐ **No**

If yes, please specify:

Facility Name	Reason(s) for Visit(s)	Date of Visit	Follow-Up Care?

2) Have you been admitted to a hospital or any other facilities since your last visit to our office? ☐ **Yes** ☐ **No**

If yes, please specify:

Facility Name	Reason(s) for Admission	Admission Date	Discharge Date	Follow-Up Care?

3) Have you had any medical tests performed since your last visit to our office? ☐ **Yes** ☐ **No**

If yes, please specify:

Test Name	Date	Where?	Follow-Up Care?

4) Have you developed any new allergies or had a bad reaction to a medication or food since your last visit to our office?
☐ **Yes** ☐ **No**

If Yes, please describe: _____

5) Have you been evaluated by a specialist such as a provider for diabetes, heart, kidney, cancer, eyes, gynecology) since your last visit to our office? ☐ **Yes** ☐ **No** *If yes, please specify:*

Provider Name	Reason for Visit(s)	Date of Visit(s)

6) Have you received any vaccinations since your last visit to our office? ☐ **Yes** ☐ **No**

If Yes, please specify the vaccinations you received and date(s): _____

_____

7) Have you started any new medications since your last visit to our office? ☐ **Yes** ☐ **No**

If Yes, please specify: _____

_____

8) Are there any other concerns that you would like to discuss during your visit today?

_____

_____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____