Patient Agenda Form

Name _____ DOB: _____ Date: _____

Please take a moment to answer the questions below. We ask that you limit your concerns during today's visit to a maximum of 2.

1) _____ 2) _____

Is this a routine follow up visit? _____ Are you fasting for blood work?_____

Do you need medication refills? _____ If so, do you prefer a 90day_____ or 30day supply? _____

What is the name & location or phone number of your pharmacy? _____

Please list all medications, including OTC, vitamins and supplements you are currently taking OR provide a current medication list or medicine bottles for review. We want to make sure our records are up to date.

(Please check the box next to the medications you need refilled at today's visit.)

Drug Name	Dose	Time(s) of Day Taken
☐		☐
☐		☐
☐		☐
☐		☐

Please list all allergies _____

Tobacco: Current Former Never If current, how much do you use daily? _____

If former, when did you stop? _____

Do you drink alcohol? Yes No If so, how much per week? _____

What is your pain level related to your visit today on a scale of 0-10 with 10 being in extreme pain? _____

Health Maintenance Questionnaire

Have you had your FLU SHOT? Yes No When: _____ Where: _____

Have you had your PNEUMONIA SHOT? Yes No When: _____ Provider: _____

Have you had a COLONOSCOPY or SIGMOIDOSCOPY? Yes No When: _____ Provider: _____

Have you had a FECAL OCCULT STOOL TEST? Yes No When: _____ Provider: _____

Have you had a MAMMOGRAM? Yes No When: _____ Where: _____

Have you had a PAP SMEAR? Yes No When: _____ Where: _____

Are you DIABETIC? Yes No

If so, have you had your diabetic eye exam? Yes No When: _____ Where: _____

Have you fallen in the last year? _____ If so, did the fall result in an injury? _____

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please check the most accurate answer.	Not at all (A)	Several days (B)	More than half the days (C)	Nearly every day (D)
1. Little interest of pleasure in doing things	o	o	o	o
2. Feeling down, depressed, or hopeless	o	o	o	o
3. Trouble falling or staying asleep, or sleeping too much	o	o	o	o
4. Feeling tired or having little energy	o	o	o	o
5. Poor appetite or overeating	o	o	o	o
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	o	o	o	o
7. Trouble concentrating on things, such as reading the newspaper or watching television	o	o	o	o
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	o	o	o	o
9. Thoughts that you would be better off dead, or of hurting yourself in some way	o	o	o	o
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
10 If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	o	o	o	o

SIGNATURE: PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE)

SIGNED _____ PRINTED NAME _____

RELATIONSHIP TO PATIENT _____

Please note that it is very important that you see your Primary Care Provider regularly to discuss the "need for" and the "scheduling of" all preventive testing and vaccinations. If you do not have a primary care provider and need assistance, you may contact the Covenant Health Call Center at (865) 541-4500 and they can assist you in identifying a qualified primary care provider that can best meet you healthcare needs.

PROVIDER INITIALS: _____