Agenda for Appointment

Name: Date:

Dear Patient:
Your appointment today is for 20 - 30 minutes. This is not a lot of time. Please note that appointments that run longer than 30 minutes will be charged the 30 – 45 minute appointment rate. To save time and money, please complete this form.

INSURANCE CHANGE: Has your insurance changed since your last appointment here? ☐No ☐Yes: _____

MEDICAL PROBLEMS
Since your last appointment with your provider (i.e. Dr. Massoumi, Kim, Lauren or McKenzie) have you experienced a **NEW ONSET** or **WORSENING** of any of the problems listed below? (Please circle or check "yes/no" as appropriate)

BODILY SYSTEM	**PROBLEMS** (please circle)	Yes	No	Please Explain
Weight	Weight gain. Weight loss.			
Eyes	Blurry or worsening vision.			
Ears/Nose/Mouth/ Throat	Throat tightening.			
Cardiovascular	Increased blood pressure. Chest pain.			
Respiratory	Difficulty breathing. Shortness of breath			
Gastrointestinal	Nausea. Vomiting. Constipation. Diarrhea			
Genitourinary	Difficulty urinating			
Muscular	Muscle twitches. Muscle tightness. Muscle spasms			
Integumentary	Skin rashes. Hives. Itchy skin. Psoriasis. Eczema. Acne			
Neurological	Headaches. Dizziness. Lightheadedness			
Endocrine (Thyroid)	Feeling hotter or colder than those around you.			
Endocrine (Females Only)	Change in menstrual cycle			
Hematologic/Lymphatic	Easy bleeding or bruising. Swollen legs			
Allergies/Immune	Recent cold, sinus infection, or other recent illness.			

- **Do you have paperwork (e.g. forms, applications, letters) for your provider to complete for you today?** ☐No ☐Yes (please explain): _____

- **On a scale of 1 to 10 (10 being the happiest) how would you rate your mood:**

TODAY?
☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

IN THE LAST ONE TO TWO WEEKS? (Circle the average or the range)
☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

At WORST in the past two weeks?
☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

- **In the past few weeks, have you had any thoughts of wanting to end your life?** Select

- **How is your sleep?** ☐Good ☐Variable ☐Poor

(Continued on reverse)

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- **In the past week, how bad has your anxiety been?** Select

- **In the space below, write the TWO MOST IMPORTANT ISSUES (e.g. questions, problems, or symptoms) that you want to be sure to discuss with your provider today. (*Questions not listed here might not get answered today!)***

  ☐ None

  1) _____

  _____

  2) _____

  _____

- **Many people forget to take their medication(s) and/or supplement(s). What percentage of the time do you successfully remember to take your:**

  Medications? _____ Supplements? _____

*When you are done with this form, please **e-mail your form to***
DrLMassoumi@gmail.com *Thanks!!* ☺