PATIENT AGENDA FORM

Please take a moment to answer the questions below to help us prepare for your needs today. Please keep this form with you and give to our clinical staff when they greet you.

Patient name _______________________________   Date ___________________

1. What concern do you want to discuss with your physician during your appointment?
________________________________________________________________________________
________________________________________________________________________________

2. What problems or symptoms do you want your physician to be aware?
________________________________________________________________________________
________________________________________________________________________________

3. Do you have request for:
   • New Medications ____________________________________________________________
   • Refills _____________________________________________________________________
   • Referral ___________________________________________________________________
   • Test or Test Results _________________________________________________________
   • Completion of Forms ________________________________________________________
   • Work or school Excuse _______________________________________________________
   • Other ______________________________________________________________________

4. If you are a patient under our care please rate how you are doing since your last visit by circling the following choices:
   No change    a little better    somewhat better    much better

Other______________________________________________________________