 **Date of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cascade Medical Care, LLC**

**Reason for Visit**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_**

**Reason for today’s visit: (please describe the symptoms for your visit today): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Would you like your records from today’s visit sent to your primary care provider? \_\_\_\_Yes \_\_\_\_ No**

**Please check any symptoms you've experienced over the LAST ONE TO TWO WEEKS:**

**General/ Constitution**

□Activity Change

□Appetite Change

□Diaphoresis (Sweating) □Fatigue

□Fever

□Irritability

□Unexpected Weight Change

**Ear, Nose & Throat**

□Congestion

□Dental Problems

□Drooling

□ Ear Discharge

□Ear Pain

□Facial Swelling

□Hearing Loss

□Mouth Sores

□Nosebleeds

□Postnasal Drip

□ Rhinorrhea (Runny Nose)

□Sinus Pressure

□ Sneezing

□Sore Throat

□Tinnitus (Ringing in the Ears)

□Trouble Swallowing

□Voice Change

**Eyes**

□Eye Discharge

□Eye Itching

□Eye Pain

□Eye Redness

□Photophobia (Sensitivity to Light)

□Visual Disturbance (Blurred Vision)

**Respiratory**

□Apnea

□ Chest Tightness

□ Choking

□Cough

□Shortness of Breath

□Stridor (Airway Obstruction)

□Wheezing

**Cardiovascular**

□Chest Pain

□Leg Swelling

□Palpitations (Irregular Heart Beat)

**Gastrointestina**l

□Abdominal Distention (Bloating)

□Abdominal Pain

□Anal Bleeding

□Blood in Stool

□Constipation

□Diarrhea

□Nausea

□Rectal Pain

□Vomiting

**Endocrine**

□Cold Intolerance

□Heat Intolerance

□Polydipsia (Abnormal Thirst)

□Polyphagia (Abnormal Hunger)

□Polyuria (Abnormal Urination)

**Genitourinary**

□Difficulty Urinating

□Dysuria (Painful Urination)

□Enuresis (Involuntary Urination)

□Flank Pain (Low Back Pain)

□Frequency Change (Urinary)

□Genital Sores

□Hematuria (Blood in Urine)

□Menstrual Problems

□Pelvic Pain

□Penile Discharge

□Penile Pain

□Penile Swelling

□Scrotal Swelling

□Testicular Pain

□Urinary Urgency

□ Changes in Urine Stream

□Vaginal Bleeding

□Vaginal Discharge

□Vaginal Pain

**Musculoskeletal**

□ Arthralgias (Joint Pain)

□ Back Pain

□Gait Problems

□ Joint Swelling

□Myalgias (Muscle Pain)

□Neck Pain

□ Neck Stiffness

**Skin**

□Color Change

□Pallor (Paleness)

□Rash

□Wounds

**Allergy/Immunologic**

□Environmental Allergies

□Food Allergies

□Immunocompromised

 **Neurologic**

□Dizziness

□Facial Asymmetry

□Headache(s)

□ Light Headedness

□Numbness

□Seizures

□Speech Difficulty

□Syncope (Loss of Consciousness)

□Tremors

□Weakness

**Hematologic**

□Adenopathy (Swollen Glands)

□Bruising Tendency

□Bleeding Tendency

 **Behavioral**

□Agitation

□Behavioral Problems

□Confusion

□Decreased Concentration

□Dysphoric Mood (Mood Changes)

□Hallucinations

□Hyperactive

□Nervousness

□Anxiety

□Self-Injury

□ Sleep Disturbance

□Suicidal Thoughts

**Any other symptoms:**

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_