



0300004

**STANDARD AMBULATORY REVIEW**

Have you had any changes in your health since your last visit? No Yes – List below

- New allergies:
- New medical problems:
- New surgeries or procedures:
- Changes to family health status:
- Changes in personal family situation (job, move, quit smoking):

Do you need any prescription medicine renewals? Yes No Other needs?

Are you having any problems with your medicines? Yes No

Are there any changes to your medicine list from your last visit? Yes No  
What?

What is the reason for your visit today (medical or personal problems)?

**CHECK IF ANY OF THESE PROBLEMS OR SYMPTOMS HAVE BOTHERED YOU IN THE LAST TWO WEEKS (OR SINCE YOUR LAST VISIT). ADD ANY OTHER PROBLEMS:**

NONE

**GENERAL**

- Appetite change
- Fatigue, tired, weak
- Fever, chills or sweating at night
- Unexpected weight gain or loss

**BREATHING & CHEST**

- Shortness of breath
- Wheezing
- Cough
- Unable to lay flat

**MUSCLES & JOINTS**

- Muscle pain
- Joint pain or swelling
- Joint Swelling
- Weak

**BRAIN & NERVES**

- Headaches – often or bad
- Memory (hard to remember)
- Weak or numb on one side
- Shaking/Seizures
- Dizzy or fainting

**HEART & VEINS**

- Chest pain/tightness
- Palpations or heart fluttering
- Swelling of hands, feet, legs
- Dizzy or fainting
- Numb, tingling or pain in feet/legs

**SKIN**

- Color change
- Rash or wound
- Moles (skin spots)

**HEAD & NECK**

- Face pain or swelling
- Mouth pain or bleeding
- Teeth pain, loose, broken
- Neck pain or stiffness
- Swallowing trouble
- Hearing change
- Vision change
- Runny nose
- Stuffy nose

**STOMACH**

- Heartburn or indigestion
- Pain in stomach or abdomen
- Nausea or vomiting
- Constipation
- Diarrhea
- Black or bloody stool (BM)

**OTHER**

- More thirst
- Feel too hot or too cold
- Bruise or bleed easily
- Swollen glands

**MENTAL HEALTH**

- Depressed or sad
- Sleep – too much or too little
- Anxious or nervous

**URINE/SEX**

- Frequent urge with urine
- Pain or burning with urine
- Leak urine with cough/sneeze
- Blood in urine
- Sores or discharge on penis or vagina
- Menstrual period

**OTHER PROBLEMS OR SYMPTOMS**

Completed by \_\_\_\_\_ Date \_\_\_\_\_  
NAME/SIGNATURE

Interpreter present \_\_\_\_\_ Cyracom phone ID # \_\_\_\_\_  
NAME/SIGNATURE

Reviewed by \_\_\_\_\_ Entered into EMR Date \_\_\_\_\_  
NAME/SIGNATURE