Outpatient Doctor Appointment Form (Long Version)

Appointment Details (Clinic/Front Desk)

- Date of Appointment: ____ / ____ / _____
- Time: _____ Check-in Time: _____
- Clinic/Location: _____
- Provider (MD/DO/NP/PA): _____
- Reason for Visit (Chief Concern): _____
- Type of Visit: ☐ New Patient ☐ Follow-up ☐ Annual/Physical ☐ Post-hospital ☐ Other: _____

Patient Information (Patient Completes)

- Full Name: _____
- Date of Birth: ____ / ____ / _____ Age: _____
- Phone: _____ Email: _____
- Preferred Pharmacy (Name/Location): _____
- Emergency Contact: _____ Phone: _____
- Primary Care Provider (if different): _____

Insurance (Patient Completes)

- Insurance Plan: _____
- Member ID: _____
- Group #: _____
- Copay (if known): $_____

Purpose of Appointment (Patient Completes)

- Main reason you're here today:

_____

_____

- When did this problem start? _____
- How often does it happen? ☐ Constant ☐ Daily ☐ Weekly ☐ On/off
- Severity (0–10): _____ /10
- What makes it better? _____

- What makes it worse? _____

Key Symptoms (Patient Checks)

☐ Fever/chills ☐ Shortness of breath ☐ Chest pain ☐ Dizziness/fainting

☐ Nausea/vomiting ☐ Diarrhea ☐ Constipation ☐ Urinary symptoms

☐ Headache ☐ Weakness/numbness ☐ Pain (where?): _____

☐ Other:

_____

_____

Medications & Allergies (Patient Completes)

Current Medications (include dose if known)

Dose: _____ Frequency: _____

Dose: _____ Frequency: _____

Dose: _____ Frequency: _____

Dose: _____ Frequency: _____

☐ I brought my medication list ☐ I brought medication bottles

Allergies

- Medication allergies:

_____

- Reaction(s):

_____

- Food/Other allergies:

_____

Medical History (Patient Completes)

- Past Medical Problems (if any): _____

_____

- Past Surgeries/Hospitalizations (and dates if known): _____

_____

- Family History (major conditions): _____
- Social History:
  - Tobacco: ☐ No ☐ Yes (type/amount): _____
  - Alcohol: ☐ No ☐ Yes (how often): _____
  - Drugs/Substances: ☐ No ☐ Yes: _____

What You Want from Today's Visit (Patient Completes)

- Top 3 questions or concerns:

1. _____
2. _____
3. _____

- Requests: ☐ Refill(s) ☐ Referral ☐ Lab order ☐ Imaging ☐ Work note ☐ Other: _____

Clinical Use (Doctor/Clinic Completes)

Vitals / Intake

- BP: / HR: _____ RR: _____ Temp: _____
- SpO_2: _____% Weight: _____ Height: _____ BMI: _____
- Pain score (0–10): _____
- Allergies verified: ☐ Yes ☐ No
- Medication list verified: ☐ Yes ☐ No

Assessment (Diagnoses/Impressions)

1. _____
2. _____
3. _____

Plan

- Orders/Tests: ☐ Labs ☐ Imaging ☐ EKG ☐ Other: _____
- Medications Started/Changed: _____

- Referrals: _____
- Patient Education / Instructions: _____
- Return Precautions (when to seek urgent care/ER): _____

_____

Follow-Up

- Follow-up timeframe: ☐ 1 week ☐ 2 weeks ☐ 1 month ☐ 3 months ☐ Other: _____
- Next appointment date/time (if scheduled): _____

Provider Name: _____ Date: ____ / ____ / _____