

SICK VISIT

Sick Visit Intake

Tell us what's going on so we can help you fast.

Patient & Visit

PATIENT NAME _____

DATE OF BIRTH _____

TODAY'S DATE _____

What's Bringing You In Today?

MAIN SYMPTOM OR CONCERN _____

WHEN DID IT START? _____

HOW WOULD YOU RATE IT? (1 = MILD, 10 = WORST) _____

GETTING BETTER, WORSE, OR SAME?

 Better

 Worse

 Same

Symptoms — Check anything you've had in the last 7 days

RESPIRATORY / COLD & FLU

 Fever (max temp: _____ °F)

 Chills

 Body aches

 Cough (dry)

 Cough (productive)

 Shortness of breath

 Sore throat

 Runny nose / congestion

 Sinus pressure / pain

 Loss of taste / smell

 Earache / ear pressure

 Headache

GI

 Nausea

 Vomiting (# times: _____)

 Diarrhea (# stools/day: _____)

 Abdominal pain

 Loss of appetite

 Blood in stool

URINARY / GU

 Burning with urination

 Frequent urination

 Blood in urine

 Back / flank pain

 Pelvic pain

 Genital symptoms / discharge

SKIN / RASH / INJURY

 Rash (location: _____)

 Itching

 Wound / cut / bite

 Insect bite / sting

 Suspected allergic reaction

 Sprain / strain

OTHER

 Eye redness / discharge

 Pink eye

 Migraine

 Dizziness / lightheaded

 Pain (location: _____)

 Other (specify below)

OTHER / ADDITIONAL DETAILS _____

Recent Exposures & Travel

 Sick household member or coworker

 Recent travel (where: _____)

 Recent food that could be related

 New pet / animal exposure

 Recent tick / mosquito exposure

 None of the above

Self-Care & What You've Tried

- | | |
|--|---|
| <input type="checkbox"/> Rest / fluids | <input type="checkbox"/> OTC pain relief (Tylenol, Advil, Aleve) |
| <input type="checkbox"/> OTC cold/cough meds | <input type="checkbox"/> OTC allergy meds (Zyrtec, Claritin, Allegra) |
| <input type="checkbox"/> Decongestants / nasal sprays | <input type="checkbox"/> Anti-diarrheal (Imodium, Pepto) |
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Ice / heat / topical care |
| <input type="checkbox"/> Telehealth or another visit elsewhere | <input type="checkbox"/> Nothing yet |

DID ANYTHING HELP, OR MAKE IT WORSE?

Quick Health Update

ALLERGIES

DRUG / FOOD / ENVIRONMENTAL ALLERGIES

NO KNOWN ALLERGIES

 None

CURRENT MEDICATIONS

MEDICATION	DOSE / HOW OFTEN

ACTIVE MEDICAL CONDITIONS

- | | | |
|--|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma / COPD |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Pregnancy / breastfeeding | <input type="checkbox"/> Immunocompromised |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Liver disease | <input type="checkbox"/> None / not relevant |

Vital Signs (Office Use)

BP	HR	RR	TEMP	SPO2	WT	HT	BMI

Today's Goals

What would make this visit a success for you? (e.g., "I want to know if this needs antibiotics," "I need a work note," "I want to feel better by the weekend")

IF YOU HAVE ANY OF THESE — TELL US RIGHT AWAY

Severe chest pain or pressure · Difficulty breathing or shortness of breath at rest · Confusion or trouble staying awake · Stiff neck with fever · Severe headache (worst of your life) · Severe abdominal pain · Signs of stroke (face droop, arm weakness, slurred speech) · Allergic reaction with throat tightness or trouble swallowing

PATIENT SIGNATURE

DATE