

ENCOUNTER WORKSHEET

Date: _____ Name: _____

1. What is the reason for today's visit:
2. Have you been able to do anything to improve this issue?
3. How long have you had this issue?
4. Is this issue getting better or worse?
5. Please list any allergies (drug, latex, food) you have?
6. Please list the medications that you take:
7. Please list any chronic medical problems that you have:
8. Please list any past surgeries:
9. Please list any medical conditions that run in your family:

Yes No Is this visit deployment related?

Yes No Do you have any learning disabilities? If yes, please list:

Yes No Are you taking any vitamins, herbals, over the counter medications or dietary supplements?

If yes, please list:

Yes No Do you use tobacco products? If yes, what kind? _____ Interested in quitting? Yes No

Yes No Do you drink alcohol? **If you consume alcohol, please answer questions below:**

What kind? _____ How often? _____

Yes No Have you ever attempted to cutback? Does your drinking make anyone angry? Yes No

Yes No Do you feel guilty about your drinking? Do you ever have an "eye-opener?" Yes No

Yes No Have you recently lost weight? If so, were you trying to lose weight? Yes No

Please rate your pain now (circle one):

0	1	2	3	4	5	6	7	8	9	10
None	Mild			Moderate			Severe			

Yes No Do you have depression or feel depressed?

If yes, are you taking medication for depression? Yes No

If yes, are you having any thoughts of hurting yourself or ending your life? Yes No

NOT TO BE FILED IN MEDICAL RECORD