Name_____ Date:_____

VISIT PLANNING:
What is the reason for this visit? Is there something else you are concerned about?

_____

_____

Have you seen other health care providers, had tests done or been to the hospital since our last visit?

_____

PAIN: In the past month, how much bodily pain have you generally had?

no pain very mild pain mild pain moderate pain severe pain

FEELINGS: In the past month, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, or not caring about your life?

not at all slightly moderately quite a bit extremely

HEALTH HABITS: In the past month, how often did you practice good health habits such as using a seat belt, getting exercise, eating well, getting enough sleep, not smoking, brushing your teeth, wearing safety helmets, taking your medicines?

all the time most of the time some of the time a little of the time none of the time

Is there a health habit you would like to work on improving? _____

Would you like help with a goal you have for improving your health? _____

CONFIDENCE: Are you confident in managing your health?

I can do it 1 2 3 4 5 6 7 8 9 10 I can't do it

SUPPORT: In the past month, if you needed someone to listen or to help you, was someone there for you?

yes, as much as I want yes quite a bit yes, some yes, a little no, not at all

MEDICINES:
Have you added any new medicines or stopped any medicines recently?_____

Are your medicines making you ill? _____

How often do you miss a dose of your medicine? _____

Are you having any trouble getting your medicines? _____

Please bring all your medicines or an up-to-date list with you to every visit and ask for refills.

NAME: _____ Date: _____ Best phone number_____

***Has your phone number or address changed recently? _____**

Your Blood Pressure Today:

SYS: _____ (systolic blood pressure - the higher number)

DIA: _____ (diastolic blood pressure - the lower number)

PULSE:_____

Your Blood Pressure Goal:

I have a history of diabetes, kidney disease,
a heart attack or hardening of the arteries.....Your blood pressure GOAL is **130 / 80** or lower

I do **NOT** have a history of diabetes, kidney disease,
a heart attack or hardening of the arteries.....Your blood pressure GOAL is **140 / 90** or lower

Today my blood pressure is (please circle)

in GOAL (doing well) not in GOAL (needs some work) different from my home readings

Your Weight Today:

My weight is _____ My height is_____(If you don't know, I will measure you.)

Today my weight is: (please circle)
is doing well needs attention (overweight) is in trouble (obese)

Your Height without Shoes	Your weight... needs attention if:	is in trouble if:
4 Feet 10 Inches	Over 119	Over 143
4 Feet 11 Inches	Over 124	Over 148
5 Feet	Over 128	Over 153
5 Feet 1 Inches	Over 132	Over 158
5 Feet 2 Inches	Over 136	Over 164
5 Feet 3 Inches	Over 141	Over 169
5 Feet 4 Inches	Over 145	Over 174
5 Feet 5 Inches	Over 150	Over 180
5 feet 6 Inches	Over 155	Over186
5 Feet 7 Inches	Over 159	Over 191
5 Feet 8 Inches	Over 164	Over 197
5 Feet 9 Inches	Over 169	Over 203
5 Feet 10 Inches	Over 174	Over 209
5 Feet 11Inches	Over 179	Over 215
6 Feet	Over 184	Over 213
6 Feet 1 Inches	Over 189	Over 221
6 Feet 2 Inches	Over 194	Over 233
6 Feet 3 Inches	Over 200	Over 227
6 Feet 4 Inches	Over 205	Over 233