Outpatient Visit Assessment Questionnaire

Patient Information

Full Name

Date of Birth

Date of Visit

Medical Record Number

Chief Complaint

What brings you in today?

Medical History

Any past medical history or chronic conditions?

Past surgical history:

Current medications (please list):

Any allergies?

Review of Systems

Do you currently have any of the following symptoms?
(Check all that apply)

- [ ] Fever
- [ ] Cough

- [ ] Fatigue
- [ ] Pain
- [ ] GI Issues
- [ ] Other

Social History

Do you smoke?

Select

Do you drink alcohol?

Select

Other social habits or concerns:

Assessment Notes

Provider Notes:

Plan & Recommendations

Next steps or recommendations: