

Patient-Doctor Encounter Form – “My Concerns Today Are ... ”

To be used for office visits and/or in the hospital when the doctor visits

Name of Patient _____

Date of Birth _____

Date Today _____

Doctor's Name/Clinic _____

To the Doctor: Because I know your time is valuable; because I know that the more you know about me, the better you can diagnose and treat me; because I know that if I present my problems more efficiently, you will be able to save time; because I know that you may not be able to get to all my concerns today, and I want to give you the whole list first so you can decide what should be done today, and what needs to wait until another visit; because I want to make the communication between us as clear as possible:

To the Doctor: MY CONCERNS TODAY are numbered on the back of this page.

Instructions to patient: *Start on the back of this page and*

- List your concerns, starting with #1, and put your most pressing concerns at the top of your list.
- After you have filled out your list of concerns, then take another sheet of paper, *for each concern listed*, and write about that concern. These will be called your “Concern Pages.” **If you could type these, that would be great.** Be sure and answer these questions about each one of your concerns:
 - a. What date did it start (approximately, or how many days, weeks, or months ago)?
 - b. What are the symptoms that concern you, and what other symptoms are also there?
 - c. Describe how the concern has progressed over time. What came first? What happened next? Then what happened next? And next? Has it gotten better or worse? Does it come and go, or is it steady? What things make it better or worse? Is it related to food or an empty stomach, a certain position, or exercise? Did it start one place, and then extend to other parts of your body? If pain, is it throbbing or steady? – If you find yourself rambling, then start over and organize your words better. The more organized your description, the better chance the doctor has in diagnosing you and treating you correctly.
 - d. *Go back through each Concern Page*, and find every *symptom* that you listed (for example, nausea or chest pain). Write a letter **above** each of the symptoms, using the following rating system (and using a red pen or different color ink if possible).

Frequency/Severity of Symptoms Rating

E – Very infrequently or not really bothersome **D** – Occasionally or a little bothersome **C** – Moderately or somewhat a problem **B** – Often or aggravating **A** – Very often or a big problem

For Patient: In the following list of symptoms, underline those that have occurred in the last several weeks. Then put an A, B, C, D, or E in the blank to the left of each symptom underlined, using the rating system above. Circle the symptoms that are worrisome or aggravating. **UNLESS YOU ALSO MENTION THE FOLLOWING SYMPTOMS IN YOUR CONCERN PAGES, WE MAY NOT TALK ABOUT THESE TODAY.** **For Doctor:** **Review of Systems, this date.**

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| ___ Fever ___ Unintentional weight loss ___ Unintentional weight gain ___ Unusual/extreme tiredness ___ Loss of appetite ___ Excessive appetite ___ Excessive thirst ___ Dry mouth ___ Swollen glands/lymph nodes ___ Weakness ___ Fainting ___ Eye pain ___ Eye discharge ___ Blurred vision ___ Double vision ___ Other trouble with eyesight ___ Earache/ear pain ___ Hearing problems ___ Dizziness/feeling of motion ___ Hay fever/sinus allergies ___ Runny nose/congestion ___ Sore throat ___ Headache | ___ Memory problems (new) ___ Anxiety ___ Depression ___ Grieving ___ Family/personal difficulties ___ Insomnia/sleeping problems ___ Excessive sleepiness ___ Suicidal thoughts ___ Chest pain ___ Chest pain while sitting ___ Chest pain while exercising ___ Heart palpitations ___ Abnormal heart beat ___ Leg pain while walking ___ Tightness of chest ___ Shortness of breath ___ Short of breath when sleeping or lying down ___ Short of breath when walking ___ Breathing is painful ___ Wheezing ___ Dry cough | ___ Coughing up pale phlegm ___ Coughing up colored phlegm ___ Coughing up blood ___ Mostly nighttime coughing ___ Problems swallowing ___ Stomach ache/pain/burning ___ “Heartburn” ___ Nausea ___ Vomiting ___ Diarrhea ___ Constipation ___ Excessive stomach cramping ___ Excessive stomach bloating ___ Excessive gas ___ Blood in stool ___ Painful urination ___ Blood in urine ___ Excessive urination ___ Difficulty urinating ___ Frequent urination ___ Inability to hold urine ___ Urgent urination or accident ___ Unusually urinating at night | ___ Joint pains/problems ___ Muscle cramps/aches ___ Muscle weakness ___ Back pain ___ Swelling of legs or ankles ___ Changing mole ___ Rash ___ Itching ___ Sores/other skin problems ___ Erection problems (men) ___ Breast lump/mass ___ Excessive menstrual cramps ___ Abnormal/late period ___ Vaginal/vulva itching ___ Abnormal vaginal discharge ___ Unusual pelvic pain ___ Bleeding after menopause ___ Smoker? (Yes or No) ___ Alcohol use? (Yes or No) ___ Addiction/drugs? (Yes or No) ___ Exercise? (Yes or No) ___ Birth control? (Yes or No) ___ Number of children |
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