Coal Creek Family Medicine

Pre-Visit Planning Form

Appt Date: _____ Provider: _____ Reviewed by: _____

Name: _____ DOB: _____ Today's Date: _____

Please answer the following questions prior to your visit with your provider. Your responses will help us make sure your chart is complete and allow for the best care possible.

Please list your preferred pharmacies – Local and Mail Order:

Pharmacy Name	Location	Local Pharmacy or Mail Order

Please list **all** prescription medications:

Medication Name and Dose	How often do you take it?

Please list **any and all** over the counter supplements you are taking:

Medication/Supplement Name and Dose	How often do you take it?

Do you have any Allergies? If yes, please list below:

Allergy	Reaction

Do you see any other doctors or specialists? If yes, please list below:

Type of Specialist	Name of Physician	Phone Number

Have you been diagnosed with any **NEW** conditions in the past 12 months by anyone outside of CCFM? If yes, please list below:

New Condition	Who diagnosed you?

Have you had any recent surgeries in the past 12 months that your provider at CCFM is not aware of? If yes, please list below:

Type of Surgery	Who performed the surgery	Where was the surgery performed

Have you been to Urgent Care, ER or hospitalized in the last 12 months? If yes, please list below:

Name of Facility	Date of Visit	Location/Address

Have you had any vaccines in the last 12 months **not** completed at CCFM? If yes, please list below:

Name of Vaccine	Date given	Location/Facility

Do you have a current need for assistance with housing, transportation, food etc.? If yes, please list below.

_____

_____

_____

Do you have any concerns you would like to discuss with your provider?

_____

_____

_____

Do you need any forms filled out at this appointment? (ex. Biometric forms, school forms, parking permits etc.)

_____

Please list your preferred Phone Number	