



# Pre-visit Checklist

Patient name: \_\_\_\_\_ Todays Date: \_\_\_\_\_

DOB: \_\_\_\_\_ PCP: \_\_\_\_\_

Date/reason for last visit: \_\_\_\_\_

Any hospital/ER/Urgent Care/Specialist visits since last visit:  No  Yes

Where/When/Why/Who/Outcome: \_\_\_\_\_

**Medication Reconciliation:** Review current medication list in the EHR. Any new medications? Over the counter/ herbal/ vitamins/teas, etc. Review each medication and ask if any side effects/problems/able to afford the medications? Are any due for refill in the next 90 days? Remind to bring all medications in the original bottle for both prescribed and over the counter to the visit.

Pneumonia Vaccine: Date received – \_\_\_\_\_

Influenza Vaccine: Date received – \_\_\_\_\_

Shingles Vaccine: Date received – \_\_\_\_\_

Colonoscopy: Date received – \_\_\_\_\_ n/a \_\_\_\_\_ Due: \_\_\_\_\_

Fecal Occult Stool: Date received – \_\_\_\_\_ n/a \_\_\_\_\_ Due: \_\_\_\_\_

Mammogram: Date received – \_\_\_\_\_ n/a \_\_\_\_\_ Due: \_\_\_\_\_

Cervical Screening: Date received – \_\_\_\_\_ n/a \_\_\_\_\_ Due: \_\_\_\_\_

Medical Eye Exam: Date completed – \_\_\_\_\_

Diabetes Foot Exam: Date completed – \_\_\_\_\_

Any concerns or problem other than reason for office visit to discuss with the doctor? \_\_\_\_\_

Labs due prior to this visit? Yes – have lab obtained prior to visit to allow for results and treatment at time of the office visit if possible.