Nurse Visit

Center for Integrative Health · 755 Mt Vernon Hwy NE Suite 350 Atlanta, GA 30328· (404) 255-5774 Fax (404) 255-5994

Date: **Name:** **Age:** **Date of Birth:**

Last First M.I. (Preferred)

1. Reason for today's visit:_____

2. If you have symptoms, please describe:_____

_____

Date it began: _____ Date of most recent occurrence: _____ . Is it constant or periodic?_____

3. Date of last normal period _____ 4. What do you do to avoid unwanted pregnancy? _____

4. **Your Signature** _____

OFFICE USE ONLY

Wt._____ Ht. _____ T. _____ BR (R) _____ (L) _____ Pulse _____ Circle all areas examined. Comment on Variant findings only.

Studies – IN OFFICE							Studies – Out ☐ Fasting ☐ _____ hr. P.P.
UA	Hemoccult x 1	Gluc	Strep	Wet Prep	Urine Preg	Other:	CBC _____ SMA _____ PAP _____ Culture: Urine _____ Chol Tot _____ HDL _____ LDL_____ Throat_____ T-4 _____ Hemoccult x 3 _____ Tgly_____
Nebulizer __ _____ EKG_____ Vaccine _____					Other: _____ Beck A_____ Zung D_____		Sed _____ TSH _____ PSA _____ AIC _____Micral_____ Other

Assessment/Plan

☐Benefits/ Risks/ Alterations reviewed and patient voiced understanding/ agreement REFER: ☐Mammogram ☐Bone Density ☐Colonoscopy Other:

Education: BP monitoring ☐ Smoking Cessation < 3m ☐ >10m Follow up: If not improved in _____ days Recheck _____ d/ wk/ mo with _____ for_____	**Signature**: Staff Signature

Copyright 1994 rev 2011 -Dwana Bush M.D.-