Reason for Today's Visit

(Please check **all** that apply and complete the related questions.)

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1. Cold, Flu, or Respiratory Symptoms

☐ Cough ☐ Sore throat ☐ Fever ☐ Congestion ☐ Shortness of breath

- Date symptoms started: _____
- Are symptoms improving, worsening, or unchanged?
  ☐ Improving ☐ Worsening ☐ Same
- Do you currently have a fever? ☐ Yes ☐ No ☐ Unsure
- Any chest pain or difficulty breathing at rest? ☐ Yes ☐ No
- Have you tested for COVID/flu recently? ☐ Yes ☐ No
  - If yes, result and date: _____
- Any medications taken so far (OTC or prescription)?
  _____

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2. Pain or Injury

☐ Head ☐ Neck ☐ Back ☐ Joint ☐ Muscle ☐ Other: _____

- Location of pain: _____
- Date pain started: _____
- Pain level (0–10): _____
- Is the pain constant or intermittent?
  ☐ Constant ☐ Comes and goes
- Any injury, fall, or accident? ☐ Yes ☐ No
- Any numbness, weakness, or loss of control? ☐ Yes ☐ No

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3. Gastrointestinal Concerns

☐ Abdominal pain ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation

- When did symptoms begin? _____
- Any fever? ☐ Yes ☐ No
- Any blood in stool or vomit? ☐ Yes ☐ No
- Are you able to drink fluids? ☐ Yes ☐ No
- Any recent travel, illness exposure, or food changes?

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4. Skin Concerns (Photo Upload Recommended if Available)

☐ Rash ☐ Infection ☐ Mole/spot ☐ Wound ☐ Other: _____

- Location on body: _____
- When did it start? _____
- Has it changed in size, colour, or appearance? ☐ Yes ☐ No
- Any pain, itching, drainage, or bleeding? ☐ Yes ☐ No
- Have you uploaded photos? ☐ Yes ☐ No

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5. Mental Health or Emotional Concerns

☐ Anxiety ☐ Depression ☐ Stress ☐ Sleep issues ☐ Mood changes

- How long have symptoms been present? _____
- Are symptoms affecting daily life or work? ☐ Yes ☐ No
- Are you currently on medication for this? ☐ Yes ☐ No

- Are you seeing a counsellor or therapist? ☐ Yes ☐ No

- Do you have thoughts of harming yourself or others?
  ☐ Yes ☐ No
  (If yes, please seek immediate emergency care.)

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6. Chronic Condition Follow-Up

☐ Diabetes ☐ Blood pressure ☐ Asthma ☐ Thyroid ☐ Other: _____

- Which condition is being discussed today? _____

- Is this a routine follow-up or new/worsening symptoms?
  ☐ Routine ☐ New/Worsening

- Any recent changes in symptoms or readings? ☐ Yes ☐ No

- Are you taking medications as prescribed? ☐ Yes ☐ No

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7. Medication Refill or Review

☐ Refill ☐ Side effects ☐ Medication review

- Medication name(s): _____

- Have you run out or will run out soon? ☐ Yes ☐ No

- Any side effects or concerns? ☐ Yes ☐ No

- Preferred pharmacy (name/location): _____

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8. Women's / Men's Health Concerns

☐ Menstrual ☐ Menopause ☐ Fertility
☐ Prostate ☐ Sexual health ☐ Hormonal concerns

- Brief description of concern: _____

- When did this start? _____
- Any pain, abnormal bleeding, or discharge? ☐ Yes ☐ No
- Are you pregnant or trying to conceive? ☐ Yes ☐ No ☐ N/A

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9. Preventive Care / Forms / Results

☐ General check-in ☐ Test results
☐ Referrals ☐ Forms ☐ Preventive advice

- What are you hoping to review today? _____
- Any forms needing completion? ☐ Yes ☐ No
- Any recent labs or imaging done elsewhere? ☐ Yes ☐ No

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10. Other or Multiple Concerns

Please describe:

Technology & Safety Check (Virtual Visits Only)

- You are in **Ontario** at the time of this visit: ☐ Yes ☐ No
- You are in a **private and safe location** to talk: ☐ Yes ☐ No
- You agree to a phone visit: ☐ Yes ☐ No

Additional Information

Current medications: _____

Allergies: _____

Anything else the provider should know before calling?

_____

_____