Patient Name: _____ Date: _____

Please give this to the nurse

Review of Symptoms:

Please circle YES or NO below for each one

Do you have a fever?	YES	NO
Do you have any vision changes?	YES	NO
Do you have any skin rashes?	YES	NO
Do you have any shortness of breath?	YES	NO
Do you have any chest pains?	YES	NO
Do you have any nausea or vomiting?	YES	NO
Do you have any painful urination?	YES	NO
Do you have any burning in the feet or fingers?	YES	NO
Do you have any anxiety?	YES	NO

Who is your Primary Care Physician? _____

What is the name of your pharmacy? _____

Have you been activated for the SKHC Patient Portal? YES NO

Please provide the front desk staff with your email address to receive access information to logon to SKHC Patient Portal to obtain your visit summary, lab results, prescription refill requests, etc.