Patient Pre-Visit Checklist

Name: __________________________ Date: ___________ MRN#: _______________________

☐ Provider Signature:

1. In the past 12 months did you talk with your doctor or other health care provider about your level of exercise or physical activity?
   ☐ Yes
   ☐ No

2. Have you had a flu shot since July 1, 2020?
   ☐ Yes
   ☐ No

3. In the past six months have you experienced leaking of urine?
   ☐ Yes
   ☐ No

4. During the past four weeks have you done less than you would like as a result of any emotional problems?
   ☐ Always
   ☐ Almost Always
   ☐ Sometimes
   ☐ Rarely
   ☐ Never

5. In general, would you say your health is: (please check one)
   ☐ Excellent
   ☐ Very Good
   ☐ Fair
   ☐ Poor