Robert David Tufft MD

Appointment Form

Name of Patient_____

Reason for the appointment (check) Date of Appt_____

( ) New problem Type of Problem_____

( ) Health Review/ Medication Check and Wellness Visit

( ) Physical Examination Routine

Complaint_____

Duration_____ Severity_____ Pain Scale(1-10)_____

Treatment to Date_____ Other Physicians Consulted_____

System Review

Body Organ	Complaint	Duration
Constitutional (fever, weight loss, etc)		
Eyes/Ears/Nose/Throat		
Cardiovascular (chest pain etc)		
Respiratory		
Stomach/Intestines		
Urinary/ Genital		
Skin (rash,lesions)		
Musculoskeletal		
Neurologic/Psycological		
Allergic		
Other:		

Other Concerns You wish to discuss with Dr. Tufft :

_____

Signature _____

Date_____