The Office of Leila Rhodes M.D.

Prescription Refill Evaluation

Visit Date	Last Name	First Name	MI	Date of Birth	Height	Weight

Visit Information:

1.	What is the reason for this visit? (Chief Complaint)			
2.	Have you had this before?		◯ **Yes**	◯ **No**
	If so, when?			
3.	When did your symptoms begin?			
4.	Where is the location of the problem?			
5.	Are your symptoms always present or do they come and go?	◯ **always present**	◯ **come and go**	
6.	On a scale of 1-10, rate the severity of your symptoms;1 being mild and 10 being severe.			
7.	Describe your symptoms			
8.	Is there anything that makes your symptoms better?		◯ **Yes**	◯ **No**
	If yes, what have you tried and what were the results?			
9.	Is there anything that makes your symptoms worse?		◯ **Yes**	◯ **No**
	If yes, what happened and what were the results?			
10.	Since the onset of your chief complaint, please select the status of your symptoms?			
	◯ **symptoms are getting better**	◯ **symptoms are getting worse**	◯ **symptoms are staying the same**	

Depression Screening: Important Notice: The information gathered on this questionnaire will remain confidential.

	Over the last 2 weeks, how often have you been bothered by any of the following problems? Please select the option that applies to each feeling.	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1.	Little interest or pleasure in doing things	◯	◯	◯	◯
2.	Feeling down, depressed, or hopeless	◯	◯	◯	◯
3.	Trouble falling or staying asleep, or sleeping too much	◯	◯	◯	◯
4.	Feeling tired or having little energy	◯	◯	◯	◯
5.	Poor appetite or overeating	◯	◯	◯	◯
6.	Feeling bad about yourself or that you are a failure or have let yourself or family down	◯	◯	◯	◯
7.	Trouble concentrating on things, such as reading the newspaper or watching television	◯	◯	◯	◯
8.	Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	◯	◯	◯	◯
9.	Thoughts you would be better off dead, or of hurting yourself in some way	◯	◯	◯	◯
				[For Office Use Only:	0]
10.	If you selected any problems above, how difficult have these problems made it for you to do our work, take care of things at home, or get along with other people?				
	◯ **Not difficult at all**	◯ **Somewhat difficult**	◯ **Very difficult**	◯ **Extremely difficult**	

The Office of Leila Rhodes M.D. / 6525 La Jolla Blvd, La Jolla, CA 92037 / 858-454-5557

Visit for Prescription Refill:

1.	What is the name of the medication you wish to discuss?		
2.	What is your current dose and frequency?		
3.	What do you take medication for?		
4.	Is the medication working for you?	○ Yes	○ No
5.	Are there any negative side effects from this medication?	○ Yes	○ No
	If yes, please describe the side affects you are experiencing.		
6.	Do you have any allergies to medications?	○ Yes	○ No
	If yes, please list the medication, the reaction and severity of the reaction.		
7.	Would you like a refill?	○ Yes	○ No
	If yes, please provide your Pharmacy Contact Information: (Name, Address or Location, Phone Number)		

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