Pre-Appointment Questionnaire

Appointment Date/Time: _____

First Name Middle Initial Last Name Date of Birth

_____ _____ _____ _____

What is the reason for your appointment today?

_____

Have you had any medication changes or health problems since your last appointment?

_____

Have your symptoms improved, worsened, or remained the same since your last visit?

Symptom

_____ □ Improved

□ Worsened

□ No Change

Symptom

_____ □ Improved

□ Worsened

□ No Change

Symptom

_____ □ Improved

□ Worsened

□ No Change

Symptom

_____ □ Improved

□ Worsened

□ No Change

Symptom

_____ □ Improved

□ Worsened

□ No Change

Symptom

_____ □ Improved

□ Worsened

□ No Change

Have you been to the emergency room, hospital, or any other provider since your last visit?

□ No □ Yes (specify): _____

Lifestyle

Smoking

Do you smoke?

□ No □ Yes If yes, how much and how often?

_____

Medication Adherence

Do you have trouble taking any of your medications?

□ No □ Yes If yes, please specify:

_____

Alcohol

How often do you have a drink containing alcohol?

□ Never □ Monthly or Less □ 2-4 times per month □ 2-3 times per week □ 4 or more times per week

How many drinks containing alcohol do you have on a typical day?

□ 1 or 2 □ 3 or 4 □ 5 or 6 □ 7 to 9 □ 10 or more

How often do you have six or more drinks on one occasion?

□ Never □ Less than monthly □ Monthly □ Weekly □ Daily or almost daily

Are there any changes to your family medical history?

_____

Have you recently developed an allergy to any of your medications?

□ No □ Yes (specify): _____

Please list your current pharmacy:

_____

Do you have any other concerns?

□ No □ Yes (specify): _____

Has your insurance changed since your last visit?

□ No □ Yes (specify): _____

Review of Systems – check the box if you are **currently** experiencing any of these

General/Endocrine

□ Weight Change
□ Night Sweats
□Fever/Chills
□ Goiter
□ Freq. Infections
□ Weakness/Paralysis
□ Lymph Node Enlargement
□ Heat/Cold Intolerance
□ None
□ Sinusitis
□ None

Skin

□ Hair/Nail Change
□ Brittle Nails
□ Rashes/Eczema
□ Dry Skin
□ Itching
□ Hives
□ None

Head, Eyes, Ears, Nose

□ Headache
□ Blurry Vision
□ Ear Infections
□ Postnasal Drip
□ Trauma
□ Eye Pain/Discharge
□ Hearing Problems
□ Vision Changes/Glasses
□ Ringing in the Ears

Mouth

□ Sores
□ Hoarseness
□ Bleeding Gums
□ Sore Throat
□ Loss of Taste
□ None

Lungs

□ Trouble Breathing
□ Chest Pain
□ Coughing Blood/Sputum
□ Cough/Wheeze
□ None
□ Pain in the Legs
□ Poor Circulation
□ Murmur
□ Edema/Swelling
□ Varicose Veins
□ None

Cardiovascular

□ Chest Pain
□ Cyanosis (blue skin)
□ Cold Hands/Feet
□ Anemia
□ Palpitations
□ Nausea/Vomiting
□ Abdominal Pain
□ None

Gastrointestinal

□ Change in Appetite
□ Indigestion/Heartburn
□ Diarrhea/Constipation
□ Hernia
□ Gas/Bloating
□ Numb/Tingling
□ Muscle Pain
□ Bursitis
□Neck Pain/Stiffness
□ Joint Pain
□ None

Bones, Joints, Muscles

□ Arm Pain
□ Hip Pain
□ Leg Pain
□ Bone Pain
□ Back Pain

Neurological

□ Fainting/Loss of Balance
□ Gait/Coordination Issues
□ Dizziness/Tremors
□ None
□ Urination at Night
□ Incontinence
□ Prostate Problem
□ None

Genitourinary

□ Blood in Urine
□ Increased Frequency/Urgency
□ Decreased Sex Drive
□ Pain

Pregnancy – Females only

□ Pregnant
□ Trying to Become Pregnant
□ Birth Control

Type of Birth Control: _____