

PRE-APPOINTMENT QUESTIONNAIRE



Birthdate: mm/dd /yyyy

Name: Last, First, MI

Today's Date

Phone: _____

ANY CHANGE IN ADDRESS, PHONE, INSURANCE, ETC? _____

NO CHANGE

1. What is your main purpose in coming to our office today? (If you have a new complaint, indicate how long it has been present, what it feels like, what makes it better or worse, and what you are concerned the problem might be.)

2. Do you have any other concern? Yes (list) No _____

3. Are you experiencing any of the following symptoms in a new or more intense way than previously reported? Especially if related to today's concern. (Answer "yes" by **CIRCLING** the appropriate symptom.)

Constitutional symptoms: fever, weight loss, unusual fatigue

Eyes: double vision, sudden loss of vision, runny or itching

Ears, nose, mouth and throat: sore throat, runny nose, ear pain

Cardiovascular: chest pain, palpitations, swelling of legs

Respiratory: cough, sputum, wheezing, shortness of breath

Gastrointestinal: nausea, vomiting, abdominal pain, constipation, diarrhea, blood in stools

Genitourinary: irregular menses, vaginal bleeding after menopause, frequent or painful urination, bloody urine, impotence

Skin: rash, changing mole

Neurological: headache, weakness or numbness, dizziness, falling

Musculoskeletal: joint pain, muscle pain or weakness

Psychiatric: depression, anxiety, suicidal thoughts

Endocrine: excessive thirst, cold or heat intolerance, breast mass

Hematologic: unusual bruising or bleeding, enlarged lymph nodes

Allergic: hay fever, medication reaction, skin reaction

None of the above. **Other?** _____

4. Will ANY of your prescriptions run out before your next planned visit?

Yes (list below) No

Medications	Mg.	# per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

It is best to bring ALL medications and supplements to EACH visit.

If in pain please place an X to indicate severity										
0	1	2	3	4	5	6	7	8	9	10
No						Moderate				Worst pain
pain						pain				imaginable

4. Has anything new come up in your family? (For example, have any of your blood relatives recently developed a new illness?) Yes (list below) No

5. Have you developed any new drug allergies? Yes (list below) No

6. What do you do for exercise? _____ How long? _____ How often? _____

NOTE: Brisk walking for 30 minutes most days is associated with a 30-percent reduction in the risk of heart attacks.

7. How much tobacco do you smoke or chew per day? _____

NOTE: It is recommended that you stop using tobacco. We can help you quit. I wish to quit.

8. How many times in the past year have you had 5 or more (women: 4 or more) alcohol drinks per day? _____

9. How much caffeine do you consume per day? (i.e., coffee, tea, chocolate, soda) _____

10. What method of birth control do you use? pill/patch/ring/insert, Vasectomy/tubal ligation/hysterectomy, IUD, Condoms, Natural methods, Not sexually active, Wish to get pregnant, Menopausal, Other

NOTE: Assessing the risk of pregnancy is vital to the prudent selection of medications, and parenting, is of course, at the heart of the "FAMILY Practice".

_____ I have reviewed the HFM Privacy Policies and know a copy is available to me in print or on the web. **Please initial.**

_____ I am aware of HFM Financial Policies; I am prepared to pay today up to \$300.00, for services not covered by my insurance; I will pay in full any residual after their processing and my receipt of HFM's billing; I am aware of a rebilling fee if more than one statement is required. **Please initial.**

Are there medical records we should see for this visit? Yes / No Where are they? _____?

Do you have any form(s) that require completion? Yes / No

INFO ONLY: Who speaks for you if you can not? Check out - <http://www.doh.wa.gov/livingwill/default.htm>