APPOINTMENT QUESTIONNAIRE

Name: _____ **Date of birth:** _____ **today's date:** _____

HAVE YOU PROVIDED THE RECEPTION DESK WITH YOUR INSURANCE CARD, ADDRESS AND 2 CONTACT PHONE NUMBERS? THIS INFORMATION CAN HELP US FACILITATE COMMUNICATION OF RESULTS, AND THE SCHEDULING OF REFERRALS AND DIAGNOSTIC TESTS.

1. What is the 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. Are you experiencing any of the following symptoms in relation to your main concern?
(Answer "yes" by circling the appropriate symptom.)

Constitutional symptoms: fever, chills, weight loss, extreme fatigue

Eyes: double vision, sudden loss of vision, itching, blurred vision

Ears, nose, mouth and throat: sore throat, runny nose, ear pain, vertigo, sneezing, nasal congestion, nose bleeds

Cardiovascular: chest pain, palpitations, shortness of breath when laying flat, leg swelling

Respiratory: cough, wheezing, shortness of breath;

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

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

Skin: rash, changing mole, itching,

Neurological: persistent weakness, numbness on one side of the body, falling, seizures

Musculoskeletal: joint pain, muscle weakness, back pain

Psychiatric: depression, anxiety, suicidal thoughts, difficulty falling asleep or maintaining sleep, tension

Endocrine: excessive thirst, cold or heat intolerance, breast mass, nipple discharge, excessive sweating,

Hematologic: enlarged lymph nodes, anemia, easy bleeding

Allergic: hay fever,

3. Has anything new come up in your family history? ☐Yes (list below) ☐No (Please skip question if this is your 1st visit)

_____

4. Do you have any drug allergies? ☐Yes (list below and do **include the reaction** you had to the medication) ☐No

_____

5. Are you having regular periods?

☐Yes **First day of your last period** _____ ☐No due to ☐Menopause (year) _____ ☐Hysterectomy (year) _____

6. What method of birth control do you use?
☐Not applicable ☐Pill ☐Patch ☐Vaginal ring ☐Vasectomy ☐Tubal ligation (year) _____

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

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

9. How much alcohol do you consume per week? _____

10. What do you do for exercise? _____ How often per week? _____

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If you are here for a preventative health examination, or this is your first visit to this office, please complete the following:

Marital status: ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed **Name of spouse**: _____

Occupation: _____ **Name of employer:** _____

Medications: (Name, strength, how often per day):_____

_____

_____

_____

Have you ever had a sexually transmitted disease? ☐ yes _____ ☐ no

Obstetrical history No. of Pregnancies: _____ No. of deliveries ☐ vaginal _____ ☐ c-section _____

Immunizations (please list date)

Tetanus _____ Pneumovax _____ Influenza _____

Hepatics A series _____ Hepatitis B Series _____ Guardasil _____

Meningitis _____ MMR _____ Varicella _____

Preventative Health

☐ Last Colonoscopy (date, location, findings) _____

☐ Last Mammogram (date and location) _____ ☐ Breast Implants present

☐ Last Bone Density (date and location) _____

☐ Last Pap smear (date) _____ ☐ any abnormal paps? _____ Name of GYN: _____

Family History (Please list family member affected)

☐ Depression/Anxiety: _____ ☐ Asthma: _____

☐ Lung Disease: _____ ☐ Lung Cancer: _____

☐ Heart Disease: _____ ☐ Diabetes: _____

☐ Hypertension: _____ ☐ High Cholesterol: _____

☐ Breast Cancer _____ ☐ Colon Cancer: _____

☐ Ovarian Cancer: _____ ☐ Cervical Cancer: _____

☐ Osteoporosis: _____ ☐ Thyroid Disorder:_____

☐ Stroke: _____ ☐ Asthma: _____

☐ Alcohol/Drug Use: _____ ☐ Skin Disorders: _____

☐ Other (specify) _____

Surgical History: (Please list date of surgery)

☐ appendectomy _____ ☐ gallbladder removal _____ ☐ tonsil and adenoidectomy _____

☐ hemorrhoid removal_____ ☐ hernia repair _____ ☐ blood transfusion: _____

☐ bladder suspension _____ ☐ colon resection: _____ ☐ breast surgery: _____

☐ knee surgery _____ ☐ shoulder surgery: _____ ☐ hip surgery: _____

☐ other: _____