

A P P O I N T M E N T Q U E S T I O N N A I R E

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)

- | | |
|--|--|
| <input type="checkbox"/> Depression/Anxiety: _____ | <input type="checkbox"/> Asthma: _____ |
| <input type="checkbox"/> Lung Disease: _____ | <input type="checkbox"/> Lung Cancer: _____ |
| <input type="checkbox"/> Heart Disease: _____ | <input type="checkbox"/> Diabetes: _____ |
| <input type="checkbox"/> Hypertension: _____ | <input type="checkbox"/> High Cholesterol: _____ |
| <input type="checkbox"/> Breast Cancer _____ | <input type="checkbox"/> Colon Cancer: _____ |
| <input type="checkbox"/> Ovarian Cancer: _____ | <input type="checkbox"/> Cervical Cancer: _____ |
| <input type="checkbox"/> Osteoporosis: _____ | <input type="checkbox"/> Thyroid Disorder: _____ |
| <input type="checkbox"/> Stroke: _____ | <input type="checkbox"/> Asthma: _____ |
| <input type="checkbox"/> Alcohol/Drug Use: _____ | <input type="checkbox"/> Skin Disorders: _____ |
| <input type="checkbox"/> Other (specify) _____ | |

Surgical History: (Please list date of surgery)

- | | | |
|---|--|---|
| <input type="checkbox"/> appendectomy _____ | <input type="checkbox"/> gallbladder removal _____ | <input type="checkbox"/> tonsil and adenoidectomy _____ |
| <input type="checkbox"/> hemorrhoid removal _____ | <input type="checkbox"/> hernia repair _____ | <input type="checkbox"/> blood transfusion: _____ |
| <input type="checkbox"/> bladder suspension _____ | <input type="checkbox"/> colon resection: _____ | <input type="checkbox"/> breast surgery: _____ |
| <input type="checkbox"/> knee surgery _____ | <input type="checkbox"/> shoulder surgery: _____ | <input type="checkbox"/> hip surgery: _____ |
| <input type="checkbox"/> other: _____ | | |