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Family Practice

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Pre-Visit Questionnaire

DATE: _____

Patient Name: _____ DOB: _____

PLEASE ANSWER EACH QUESTION:
IF YES, PLEASE MAKE NOTE IN COMMENTS

	YES	NO	COMMENTS
SINCE YOUR LAST VISIT:			
Has your address changed?	☐	☐	
Has your phone number changed?	☐	☐	
Has your insurance changed?	☐	☐	
Are you taking any new medications?	☐	☐	
Do you have any new allergies?	☐	☐	
Have you had any new lab tests, x-rays, or other tests?	☐	☐	
Have you had any new surgeries?	☐	☐	
TODAY'S VISIT			
If any, what refills do you need today?			
Is this visit related to an injury/accident?	☐	☐	
Is this visit work related?	☐	☐	

What is the <u>MAIN REASON</u> for today's visit:

_____

_____

_____

Over →

PLEASE ANSWER EACH QUESTION:
IF YES, PLEASE MAKE NOTE IN COMMENTS

	YES	NO	COMMENTS
GENERAL			
Change in appetite?	☐	☐	
Fatigue?	☐	☐	
Unexpected weight change?	☐	☐	
EAR, NOSE, THROAT:			
Trouble swallowing?	☐	☐	
RESPIRATORY			
Cough	☐	☐	
Shortness of breath?	☐	☐	
HEART			
Chest discomfort?	☐	☐	
Leg swelling?	☐	☐	
Pounding or racing heart?	☐	☐	
GI/ABDOMEN/INTESTINAL			
Abdominal discomfort?	☐	☐	
Constipation?	☐	☐	
Diarrhea?	☐	☐	
ENDOCRINE/HORMONAL			
New cold intolerance?	☐	☐	
New heat intolerance?	☐	☐	
MUSCULO-SKELETAL			
Joint pains?	☐	☐	
Trouble walking?	☐	☐	
Muscle Aches?	☐	☐	
SKIN			
Rash?	☐	☐	
NEUROLOGICAL			
Lightheaded?	☐	☐	
Numbness?	☐	☐	
Tremors?	☐	☐	
BEHAVIORAL			
Trouble falling asleep or staying asleep?	☐	☐	