Pre-Visit Questionnaire

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Name: _____
Date of Birth: _____

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?	☐	☐	_____

PRINT CLEAR FORM