NAME: ____ DOB: __________

Welcome back to our office. In order for us to better serve your needs, please complete the following questionnaire:

1. Do you have a specific question or concern that you would like addressed today?

____

____

____

Please list your current medications, both prescription, herbal and over-the-counter that you are regularly taking and list the reason why you are taking the medication.

____

____

2. Are you smoking now? If so, how much? Would you like to quit?

____

3. How much alcohol do you drink? Please circle all that apply. Never Rarely

   Less than 7 drinks per week More than 7 drinks per week

4. How much do you exercise (please circle all that apply)? Never Active lifestyle

   Exercise occasionally Exercise regularly (about how many times per week _______)

   What type of exercise do you do? ____

5. Since your last visit, have you had any medical illnesses or surgeries or hospitalizations or consultations with other physicians? If so, please describe. Please also include colonoscopy or mammogram if not ordered through our office.

____

____

6. In your family, have there been any recent major illnesses or deaths or new cancers?

____

____

7. If you are still menstruating, when was your last menses? ________________________
   Do you have regular or irregular menses? ________________________________

8. What are you using for contraception if applicable? ____________________________

Thank you for your time and for entrusting us with your care.

Name ________________________________ DOB: ____________

Please indicate by circling any of the following symptoms that you are currently experiencing:

CONSTITUTIONAL: Fatigue Fever Chills

EYES AND EARS: Vision changes Hearing difficulty

BREASTS: Lumps Tenderness Nipple discharge

CARDIOVASCULAR: Chest pain Palpitations Fainting Shortness of breath on exertion

RESPIRATORY: Shortness of breath in general

GASTROINTESTINAL: Diarrhea Constipation Loss of appetite Heartburn
Abdominal pain Jaundice Black stools Bloating

GENITOURINARY: Painful urination Bloody urine Incontinence
Painful intercourse Vaginal dryness Hot flashes
Night sweats Vaginal discharge Vaginal odor Kidney disease

SKIN: Rashes Acne Hair Growth

NEUROLOGIC: Tingling or numbness Seizures Sleeping difficulty Headache

MUSCULOSKELETAL: Joint pain Joint swelling

ENDOCRINE: Weight gain Weight loss

PSYCHIATRIC: Anxiety Depression Premenstrual symptoms

HEME/LYMPH: Easy bruising Anemia

ALLERGIC-IMMUNOLOGIC: Sinus allergy symptoms Frequent illnesses

What issues would you like to discuss today?

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____

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