Richichi Family Health
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PRE-APPOINTMENT QUESTIONNAIRE

Name: ______________________ Today's date: ____________ Appointment Date: ______________

To help us get the most out of your visit, please answer the following questions:

1. What is your 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.) ______________

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2. Are you experiencing any of the following symptoms in relation to your main concern? (Check all that apply)

Constitutional symptoms: ☐ fever ☐ weight loss ☐ extreme fatigue

Eyes: ☐ double vision ☐ sudden loss of vision

Ears, nose, mouth and throat: ☐ sore throat ☐ runny nose ☐ ear pain

Cardiovascular: ☐ chest pain ☐ palpitations

Respiratory: ☐ cough ☐ wheezing ☐ shortness of breath

Gastrointestinal: ☐ nausea ☐ vomiting ☐ abdominal pain ☐ constipation ☐ diarrhea ☐ blood in stools

Genitourinary: ☐ irregular menses ☐ vaginal bleeding after menopause ☐ frequent or painful urination ☐ bloody urine ☐ impotence

Skin: ☐ rash ☐ changing mole

Neurological: ☐ headache ☐ persistent weakness or numbness on one side of the body ☐ falling

Musculoskeletal: ☐ joint pain ☐ muscle weakness

Psychiatric: ☐ depression ☐ anxiety ☐ suicidal thoughts

Endocrine: ☐ excessive thirst ☐ cold or heat intolerance ☐ breast mass

Hematologic: ☐ unusual bruising or bleeding ☐ enlarged lymph nodes

Allergic: ☐ hay fever

3. Do you have any other concerns? ☐ Yes (please list) ☐ No ______________________

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4. Has anything new come up in your family history? (For example, have any of your blood relatives recently developed a new illness?) ☐ Yes (please list) ☐ No ______________________

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5. Have you developed any new drug allergies? ☐ Yes (please list) ☐ No ______________________

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6. What do you do for exercise? ______________ How long? ________ How often? ________
NOTE: Brisk walking for 30 minutes most days is associated with a 30-percent reduction in the risk of heart attacks.

7. How much tobacco do you smoke or chew per day? ______________________
NOTE: It is recommended that you stop using tobacco. We can enroll you in a tobacco-cessation low light laser therapy.

8. How much alcohol do you consume per week? ______________________

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

10. What method of birth control do you use? ☐ Not applicable ☐ The pill ☐ Vasectomy ☐ Tubal ligation ☐ Other (specify): ______________________