Heritage Family Medicine.com

PRE-APPOINTMENT QUESTIONNAIRE

Birthdate: mm/dd /yyyy ______ Name: Last, First, MI ______ Today's Date ______

Pager #:

The Feds require (HFM does NOT care) we ask your race (i.e., white, black, Asian, something else): ______, hispanic? Y N ☐ I decline to answer. Your preferred language is: ______ You need answer this only ONCE.

Phone: ______ **ANY CHANGE IN ADDRESS, PHONE, INSURANCE, ETC?** ______

☐ **NO CHANGE**

1. What is your main purpose in coming to our office today? ☐ Is this a post hospital or emergency room visit?
(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.) ______

What Pharmacy?

2. Do you have any other concern? ☐ Yes (list) ☐ No ______

3. Are you experiencing any of the following symptoms in a new or more intense way than previously reported? Especially if related to today's concern. (Answer "yes" by **CIRCLING** the appropriate symptom.)

- **Constitutional symptoms:** fever, weight loss, unusual fatigue
- **Eyes:** double vision, sudden loss of vision, runny or itching
- **Ears, nose, mouth, & throat:** sore throat, runny nose, ear pain, snore?
- **Cardiovascular:** chest pain, palpitations, swelling of legs
- **Respiratory:** cough, sputum, 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, weakness or numbness, dizziness, falling
- **Musculoskeletal:** joint pain, muscle pain or 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, medication reaction, skin reaction

☐ **None of the above.** **Other?** ______

4. Will ANY of your prescriptions run out before your next planned visit?
☐ Yes (list below) ☐ No

Medications	Mg.	# per day

It is best to bring ALL medications and supplements to EACH visit.

If in pain please place an X to indicate severity

0	1	2	3	4	5	6	7	8	9	10
No pain					Moderate pain					Worst pain imaginable

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

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

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 help you quit. ☐ I wish to quit.

8. How many times in the past year have you had 5 or more (women: 4 or more) alcohol drinks per day? ______

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

10. What method of birth control do you use? ☐ pill/patch/ring/insert, ☐ Vasectomy/tubal ligation/hysterectomy, ☐ IUD, ☐ Condoms, ☐ Natural methods, ☐ Not sexually active, ☐ Wish to get pregnant, ☐ Menopausal, ☐ Other
NOTE: Assessing the risk of pregnancy is vital to the prudent selection of medications, and parenting, is of course, at the heart of the "FAMILY Practice".

______ I have reviewed the HFM Privacy Policies and know a copy is available to me in print or on the web. **Please initial.**

______ My insurance premium payments are current and my insurance is in force? **Please initial.**

______ I am aware of HFM Financial Policies; I am prepared to pay today up to $300.00, for services not covered by my insurance; I will pay in full any residual after their processing and my receipt of HFM's billing; I am aware of a rebilling fee if more than one statement is required. **Please initial**.

Are there medical records we should see for this visit? Yes / No Where are they?______?
Do you have any form(s) that require completion? Yes / No
INFO ONLY: Who speaks for you if you can not? Check out - http://www.doh.wa.gov/livingwill/default.htm