PRE-APPOINTMENT QUESTIONNAIRE

Heritage Family Medicine.com

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. Do you require refills? List below.

Medications	Mg.	# per day

PLEASE bring ALL medications and supplements to EACH visit.

5. Over the past 2 weeks, how often have you been bothered by any of the following?

0-Not at all 1-Several days 2-More than half the days 3-Nearly every day

1. Little interest or pleasure in doing things
   0 1 2 3
2. Feeling down, depressed or hopeless
   0 1 2 3

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

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

8. 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.

9. How much tobacco do you smoke or chew per day? _____ **Do you "Vape"?** ☐ Yes ☐ No
NOTE: It is recommended that you stop using tobacco. We can help you quit. ☐ I wish to quit.

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

11. How would you describe your usual diet? ☐Typical American ☐Prudent ☐Special - How? _____

12. 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