# OFFICE VISIT QUESTIONNAIRE

**Name:** ________________________________ **Date of Birth:** ______________ **Doctor:** ____________________

**WHAT IS THE REASON FOR TODAY'S VISIT?** (Example: Routine follow up, Short of breath, treatment not working, etc.)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**ARE YOU HERE FOR TEST RESULTS?** (X-Ray/CT, Labs, etc.)

☐ No ☐ Yes Type of test______________________________ When_______________ Where _______________

**DO YOU HAVE ANY QUESTIONS OR CONCERNS YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR TODAY?**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**WHAT MEDICATION YOU TAKE? DO YOU NEED ANY MEDICATIONS REFILLED TODAY?**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**PHARMACY INFORMATION:** ____________________________________________________________

**ARE YOU ALLERGIC TO ANYTHING?** ☐ No ☐ Yes, please list drug(s) and reaction(s): _______________________

______________________________________________________________________________

**IMMUNIZATIONS (APPROXIMATE DATES ARE FINE)**

| | | | |
|---|---|---|---|
| Date of your last flu shot? | ___________________ | ☐ None | ☐ I would like one |
| Date of your last pneumonia shot? | ___________________ | ☐ None | ☐ I would like one |
| Date of your last tetanus shot? | ___________________ | ☐ None | ☐ I would like one |
| Date of your last Hepatitis A shot? | ___________________ | ☐ None | ☐ I would like one |
| Date of your last Hepatitis B shot? | ___________________ | ☐ None | ☐ I would like one |

**FAMILY HISTORY (POSSIBLE GENETIC ILLNESSES)**

Has anyone in your immediate family had any illnesses? *Please indicate if it was the cause of death.*

☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter

______________________________________________________________________________

**PAST MEDICAL HISTORY**

Have you developed any new problems or been hospitalized since your last visit ☐ No ☐ Yes

______________________________________________________________________________

______________________________________________________________________________

**SOCIAL HISTORY**

Do you smoke or use smokeless tobacco? ☐ No ☐ Yes ☐ Former, please list quantity: _______________________

If you are a former tobacco user, when did you quit? ______________________________________________

Do you drink alcohol? ☐ No ☐ Yes, please list quantity: ___________________________________________

Do you use caffeine? ☐ No ☐ Yes, please list type and quantity: ______________________________________

# OFFICE VISIT QUESTIONNAIRE

## GENERAL HEALTH

Do you **currently** have any of the following symptoms?

☐ Fever ☐ Productive Cough ☐ Bloody Sputum ☐ Malaise/Fatigue ☐ Night Sweats ☐ Unexplained Weight Loss
☐ Vomiting ☐ Diarrhea ☐ Sore Throat ☐ Painful/Swollen Glands ☐ Skin Rash-Blisters ☐ Stiff Neck

Do you **currently** have any of the following conditions?

☐ Pertussis ☐ Measles, Mumps, or Rubella ☐ Chicken Pox ☐ Meningitis ☐ Tuberculosis

In the last 30 days, have you traveled outside the United States? ☐ No ☐ Yes

## REVIEW OF SYSTEMS PLEASE CHECK ALL THAT APPLY

1. **Constitutional**. Have you been experiencing: ☐ Weight Gain ☐ Weight loss ☐ Fever
2. **Head/Eyes/Ears/Nose/Throat**. Do you have: ☐ Visual changes ☐ Decreased hearing ☐ Tinnitus/Ringing in the ears
3. **Respiratory**. Do you have: ☐ Snoring ☐ Hemoptysis (Coughing up blood) ☐ Dyspnea (Shortness of breath) ☐ Cough ☐ Wheezing
4. **Cardiac**. Do you have: ☐ Chest pain/discomfort/pressure/burning ☐ Sweats ☐ Trouble breathing when lying down ☐ Palpitations (Racing or skipping heart) ☐ Fainting ☐ Lightheadedness ☐ Trouble breathing at night
5. **Vascular**. Do you have: ☐ Leg pain/cramps ☐ Edema (Swelling of hands or feet)
6. **Gastrointestinal**. Do you have: ☐ Nausea ☐ Reflux (Heartburn) ☐ Bleeding ☐ Vomiting ☐ Anorexia ☐ Abdominal pain ☐ Change in bowel habits ☐ Constipation ☐ Blood in stool ☐ Dark tarry stools ☐ Hemorrhoids
7. **Genitourinary**. Do you have: ☐ Hematuria (Blood in urine) ☐ Nocturia (Frequent night time urination) ☐ Erectile Dysfunction
8. **Reproductive**. Have you: ☐ Used oral contraceptives/estrogen
9. **Endocrine**. Do you have: ☐ Goiter (Enlarged thyroid) ☐ Tremors
10. **Psychiatric**. Do you have: ☐ Depression ☐ Hallucinations
11. **Neurologic**. Do you have: ☐ Dizziness/vertigo ☐ Memory loss ☐ Seizures ☐ Headaches
12. **Dermatologic.** Do you have: ☐ Rash ☐ Open sores/wound ☐ Nodules
13. **Musculoskeletal**. Do you have: ☐ Arthritis/joint swelling or pain ☐ Myalgia (Muscle weakness)
14. **Hematologic**. Do you have: ☐ Acute anemia ☐ Thrombocytopenia ☐ Abnormal Bruising

| ______________________________ | ______________________________ |
|---|---|
| **Patient Signature** | **Date** |
| ______________________________ | ______________________________ |
| **Physician Signature** | **Date** |

---

**Patient Name:**