Pre-Appointment Questionnaire	Patient name:	
Highland Family Medicine 777 S. Clinton Avenue Rochester, NY 14620	DOB:	MR#:
	Date:	Provider:

Please answer the following questions to help you get the most out of today's visit.

What is your main purpose in coming to Highland Family Medicine today?
Please realize that unless an extended appointment has been scheduled, only one or at the most two problems can be discussed in one visit.

1.

2.

3.

4.

Are you experiencing any of the following symptoms in relation to your main concern?
Answer "yes" by circling the appropriate symptom, or write in your complaint.

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 **Allergic:** hay fever

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

What other concerns do you have?

Family History. Has anything new come up in your family history (have any of your blood relatives developed a new illness)? Please list.

Drug Allergies. Have you developed any new drug allergies? Please list.

Do you use tobacco		N		Y	What type:	Amount per day:	How many years:
Do you use alcohol		N		Y	What type:	Amount per day:	How many years:
Do you use caffeine		N		Y	What type:	Amount per day:	How many years:
Do you exercise		N		Y	What type:	Minutes per day:	Days per week:
What method of birth control do you use?							
If over 50 years of age, when was your last colon cancer screening?							
For women, when was your last:					Pap smear?		Mammogram?
Who is your health care proxy?						What is your code status?	