Pre-appointment questionnaire

To be completed before or at the patient's current visit	
Patient name:	
Date of birth:	Appointment Date:

What do you hope to accomplish today?

Is there anything you would like to work on to improve your health?

Please respond if you have one of the following conditions:

High Cholesterol	Problems with medication(s)? ☐ No ☐ Yes ☐ N/A
Diabetes	Problems with medication(s)? ☐ No ☐ Yes ☐ N/A Most recent home glucose readings:
High Blood Pressure	Problems with medication(s)? ☐ No ☐ Yes ☐ N/A Most recent home blood pressure readings:
Depression	Problems with medication(s)? ☐ No ☐ Yes ☐ N/A Any suicidal thoughts? ☐ No ☐ Yes ☐ N/A

Have you been to the emergency room, hospital or any other provider since your last visit?
If yes, please explain:

Lifestyle

Alcohol

How often do you have a drink containing alcohol?
☐ Never ☐ Monthly or less ☐ 2-4 times per month ☐ 2-3 times per week
☐ 4 or more times per week

How many standard drinks containing alcohol do you have on a typical day?
☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

How often do you have six or more drinks on one occasion?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Caffeine

Do you consume any caffeine? ☐ No ☐ Yes: How often? How much?

Exercise

Do you exercise? ☐ No ☐ Yes: How often? How long?

Smoking

Do you smoke? ☐ No ☐ Yes: How often? How much?

Birth control

Do you use any form of birth control? ☐ No ☐ Yes: What method?

Medication adherence

Do you have trouble taking any of your medications? ☐ No ☐ Yes: Describe.

Lifestyle

Are there any changes to your family medical history? For example, if a family member has received a new diagnosis, we can update your family history to reflect any changes since your last visit.

Have you recently developed an allergy to any of your medications? If yes, please describe below.

Do you have any end-of-life care plans or preferences? If yes, please bring a copy of relevant documents to your upcoming visit (e.g., your advance directive, power of attorney and health care proxy). If not, would you like to discuss your preferences?

Are you experiencing any of the following?

☐ Abdominal pain	☐ Diarrhea	☐ Headache	☐ Runny nose
☐ Anxiety	☐ Double vision	☐ Heart palpitations	☐ Shortness of breath
☐ Blood in stools	☐ Ear pain	☐ Heat/cold intolerance	☐ Sore throat
☐ Bloody urine	☐ Enlarged lymph nodes	☐ Impotence	☐ Sudden vision loss
☐ Breast mass	☐ Excessive thirst	☐ Irregular menses	☐ Suicidal thoughts
☐ Bruising	☐ Extreme fatigue	☐ Joint pain	☐ Vomiting
☐ Changing mole	☐ Falling	☐ Muscle weakness	☐ Unusual bleeding
☐ Chest pain	☐ Fever	☐ Nausea	☐ Weakness
☐ Constipation	☐ Frequent urination	☐ Numbness	☐ Weight loss
☐ Cough	☐ Hay fever	☐ Painful urination	☐ Wheezing
☐ Depression			

Do you have any other concerns? If yes, please describe below.

Source: AMA. *Practice transformation series: pre-visit planning*. 2015.

Please note that this document can be modified to meet the needs of your practice. Practices may find that emailing the form along with additional instructions and information to patients or posting it on a patient portal prior to the visit is most effective.