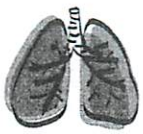

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VISIT QUESTIONNAIRE

NAME _____

VISIT DATE _____

PRIMARY DR _____

PHARMACY _____ Phone _____

REASON FOR VISIT _____

If you are new to the office or need to update your medical information, please indicate the following:

MEDICAL PROBLEMS	MEDICATIONS

ALLERGIES

PLEASE CIRCLE ANY SYMPTOMS YOU ARE CURRENTLY EXPERIENCING

Fever	Chills	Weight loss	Dizziness
Nasal congestion	Chest pain	Palpitations	Leg swelling
Cough	Shortness of breath	Abdominal pain	Nausea/vomiting
Diarrhea	Joint pains	Muscle pains	Rash
Headache	Weakness	Anxiety	Depression
Fatigue	Lightheadedness		

DO YOU HAVE ANY QUESTIONS, COMMENTS OR SUGGESTIONS FOR OUR OFFICE?

_____