

INITIAL VISIT QUESTIONNAIRE

Today's Date: _____

Name: _____ Age: _____

Birthdate: ___/___/___ Phone: (H) _____ Email: _____

Occupation: _____ Employer: _____ Phone: _____

Household Members: _____

Reason for seeking care today: _____

Other medical issues to be addressed at a later time? _____

Ongoing medical problems:

Hospitalizations and surgeries (reason and approximate date):

Medications:		
(Include prescription and over-the-counter herbs and vitamins)		
DRUG	DOSE	HOW OFTEN
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Allergies:

Other allergies:

Family history: Diabetes Heart Disease Stroke Cancer

Other Family Conditions:

Tobacco Use: Never Former (Quit date: _____)
Current use: _____ packs/day or ___ chew

Alcohol Use: None Rarely Monthly Weekly Daily

Previous Doctor / Medical Practitioner: _____

Last Complete Physical Examination: _____

Why did you to choose Evergreen for your care? _____

Patient Signature: _____

Reviewed _____