Richmond Hill Medical Home Pre-Appointment Questionnaire (Please Print)

PLEASE FAX OR BRING THIS COMPLETED FORM TO THE CLINIC AT LEAST TWO DAYS BEFORE YOUR APPOINTMENT
FAX: 912-459-1083

Name Last, First + Sponsor's Last 4	**Date of Birth:**	**Work Phone:**	**Best Contact Number:**

To make the most of your visit, please take a few moments to answer the following questions. Then please review and make any corrections or annotations on the accompanying paper that lists your medications, active medical problems, family history and allergies. It is very important to ensure your safety that the information in our electronic medical record is correct.

1. **Check all that apply:**
   - ☐ This is my initial visit
   - ☐ This is my first visit to this clinic in the past 3 years
   - ☐ I am having difficulty with: eating, dressing, walking
   - ☐ I am here to review laboratory tests or x-rays
   - ☐ This is a deployment related problem
   - ☐ I have prescriptions that need to be refilled.

   Please list:____________________

2. **Main reason for today's visit:** (if you have a new complaint, indicate how long it has been present, what it feels like, what makes it better or worse, what you think it might be):____________________

3. ☐Yes ☐No **Do you have a copy of your medication list?**
   (It is **very** important that you have an accurate list of **all** your medications. If you do not have one, please do not leave the clinic today without one. It is especially important to take your medication list with you if you go to an emergency room or see a provider outside the military network)

4. **Please list any medications you are currently taking:** ____________________

5. ☐Yes ☐No **Are your immunizations up to date? Please provide the records at least two days prior to your appointment.**

6. ☐Yes ☐No **Do you have any medication allergies? Please list:**____________________

7. For Women:
   - ☐ Yes ☐ No **Is there a possibility you are pregnant?**
   - ☐ Yes ☐ No **Are you trying to become pregnant?**
   - ☐ Yes ☐ No **Are you using Birth Control?**
   - **Date of Last Pap Smear** ____________
   - ☐ Yes ☐ No **Are you breast feeding?**
   - **Date of Last Menstrual Period** ____________
   - **Method of Birth Control** ____________
   - **Date of Last Mammogram** ____________

8. ☐ Yes ☐ No **Do you use tobacco products?** If yes, how much do you smoke or chew per day? ____________
   ☐ Yes ☐?No **Do you want to quit?**
   Note: It is recommended that you stop using tobacco. We can enroll you in a tobacco-cessation class.

9. **How much alcohol do you consume per week?** ☐ never ☐ less than 2/month ☐ few drinks/week ☐ few drinks/day ☐ other.

10. ☐ Yes ☐ No **During the past month, have you often been bothered by feeling down, depressed or hopeless?**

11. ☐ Yes ☐ No **Have you had an unintentional weight loss or gain of over 10 pounds in the last three months?**

12. ☐ Yes ☐ No **Are you concerned with any domestic violence issues at home?**

13. ☐ Yes ☐ No **Are you concerned that you or a family member may be experiencing physical, social or psychological problems related to deployment?**

Note: The Army is concerned about Post Traumatic Stress Disorder and mild Traumatic Brain Injury. These conditions can have subtle signs and symptoms and many times are noticed by spouses and family members and are not often recognized by those who are affected.

If this is your first visit to this clinic, fill out this page!

These questions should be answered the first time you visit this clinic. If you have answered them on this form at a previous visit, please skip.

Social History

1. What is your current living situation? ______________________________
2.What is your occupation? ______________________________
3.Are there any pets in the house? (Please list) ______________________________

Medical History

☐(High blood pressure	☐(Lower Back Pain
☐(Cardiovascular disease	☐(Chronic Pain
☐(High Cholesterol	☐(Reflux
☐(Depression	☐(Sleep Apnea
☐(Diabetes	☐(Fractures Location(s)__________
☐(Asthma	☐ __________
☐(Cancer Type(s):__________	☐(Other __________

Surgical/Procedural History (Please Include Childhood Surgeries)

Surgeries/Hospitalizations	Year

Family History

****PLEASE SPECIFY PATERNAL OR MATERNAL GRANDPARENT****

	Grandfather	Grandmother	Father	Mother	Brother	Sister
Cardiovascular disease						
High blood pressure						
High Cholesterol						
Coronary artery disease						
Heart Attack (Myocardial Infarction)						
Stroke (Cerebrovascular Accident)						
Diabetes						
Cancer						
Colon						
Breast						
Ovarian						
Prostate						
Other						
Mental Health						
Depression						
Schizophrenia						
Bipolar Disease						
Mental retardation						
Other__________						

Please list any other providers you are seeing outside of military facilities: ______________________________

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