DOCTOR VISIT QUESTIONNAIRE

Name of Doctor: _____ Date of Visit: _____

1. What is your main health concern right now?

   _____

2. Do you have any new symptoms, such as pain?

   _____

3. What changes have you noticed in your health since your last visit?

   _____

4. Have you experienced a fall?
   (A fall is defined as an event which results in a person coming to rest inadvertently on the ground, floor or other lower level.)

   YES NO

   If yes, when and where? _____

5. Have you started any new medications?

   YES NO

   If yes, please list: _____

6. Have you seen any other doctors before this visit?

   _____

7. Have you had diagnostic tests or other treatments?

   _____

480-219-4790 | 2250 E Germann Rd Suite 1 | www.aegishospice.com
Chandler, AZ 85286