|  |  |
| --- | --- |
|  | **Patient Questionnaire** |
|  |
| **Name:** |  | **DOB:** |  | **DOS:** |  |

1. **How are you doing since your last visit?**

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1. **How is your mood? (Circle one)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  | **Good** | **Depressed** | **Down** | **Nervous** |
|  |  |  |  |  |
|  | **Anxious**  | **Irritable** | **Agitated** | **I Don’t Know** |

1. **Have you noticed any memory difficulties?**
2. **Any new medical problems? Any new medications?**

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1. **Do you experience any of these? (Circle your answers)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Nausea Vomiting** | **Diarrhea** | **Dizziness** | **Falls** |
| **Light-Headedness** | **Unsteadiness** | **Confusion** | **Dry Mouth** |
| **Blurred Vision** | **Constipation** | **Dreams** | **Insomnia** |
| **Breathing Difficulties** | **Palpitation** | **Incontinence** | **Heart Problems** |

1. **What questions do you have for the provider?**

Please use back of this paper if more space is needed.