

# Pre-Doctor Visit Questionnaire

Patient: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Location: \_\_\_\_\_

Appt. Date: \_\_\_\_\_ Appt. Time: \_\_\_\_\_

E-mail: \_\_\_\_\_ URL: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Current Medications: \_\_\_\_\_

\_\_\_\_\_

Symptoms: \_\_\_\_\_

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Questions: \_\_\_\_\_

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