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Description of the problem: \_\_\_\_\_

When did this problem start? \_\_\_\_\_

At what time of day does the problem occur? \_\_\_\_\_

Has this ever happened before? \_\_\_\_\_

What have you done to treat this problem? \_\_\_\_\_

Have you seen another doctor and what was his/her diagnosis? \_\_\_\_\_

Are you taking any medications? \_\_\_\_\_ (You should complete the MAP-  
Personal Medication Question Guide)

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**FAMILY HISTORY**

Are your parents alive? \_\_\_\_\_ Siblings? \_\_\_\_\_

If not, what was their cause of death? \_\_\_\_\_

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**PRIOR ILLNESSES**

List any serious illnesses, surgeries that you have had and their approximate dates:

\_\_\_\_\_  
\_\_\_\_\_

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**AT THE OFFICE VISIT: REVIEW WITH THE DOCTOR**

**DIAGNOSIS:** \_\_\_\_\_

**COURSE OF TREATMENT:** \_\_\_\_\_

**MEDICATIONS PRESCRIBED AND INSTRUCTIONS:** \_\_\_\_\_

\_\_\_\_\_