JMR MEDICAL SERVICES
PRE-VISIT QUESTIONNAIRE

Please complete this form before your appointment. Your answers help our care team prepare for your visit.

Patient Name: _____

Date of Birth: 08/19/2026

Preferred Name: _____

Pronouns: _____

Appointment Date: _____

Best Phone: _____

Email: _____

Preferred Contact: n Call n Text n Email

1. REASON FOR TODAY'S VISIT

What is the main reason for your visit today?

_____

When did this concern begin? ■ Today ■ Within the past week ■ 1–4 weeks ■ More than 1 month ■ Ongoing

Please describe your symptoms, concerns, or goals for today's visit:

_____

_____

2. CURRENT HEALTH CONCERNS

Are you currently experiencing any of the following?

■ Pain ■ Fever ■ Cough ■ Shortness of breath ■ Headache ■ Dizziness

■ Fatigue ■ Nausea/vomiting ■ Changes in appetite ■ Sleep problems ■ Skin changes ■ Other

If yes, please provide details, including severity and what makes it better or worse:

_____

_____

3. MEDICAL HISTORY

Have you ever been diagnosed with any of the following?

■ High blood pressure ■ Diabetes ■ High cholesterol ■ Heart disease ■ Asthma/COPD

■ Kidney disease ■ Liver disease ■ Thyroid condition ■ Mental health condition ■ Other

Other medical conditions or important health history:

_____

Previous surgeries or hospitalizations (include approximate dates if known):

_____

_____

4. MEDICATIONS & ALLERGIES

List all prescription medicines, over-the-counter medicines, vitamins, supplements, and herbal products you currently take. Include dose/frequency if known.

Medication / Supplement	Dose	How Often	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any medication, food, latex, or environmental allergies? ■ No ■ Yes

If yes, list the allergy and reaction:

_____

5. FAMILY & SOCIAL HISTORY

Does a close family member have a history of any of the following?

■ Heart disease ■ Stroke ■ Diabetes ■ High blood pressure ■ Cancer ■ Kidney disease

Tobacco/nicotine use: ■ Never ■ Former ■ Current

Alcohol use: ■ None ■ Occasionally ■ Regularly

Other information about your family or social history you would like us to know:

_____

_____

6. PREVENTIVE CARE

When was your last routine physical/exam? _____

Are you up to date on routine vaccinations? ■ Yes ■ No ■ Unsure

Are there any screenings or preventive-care questions you would like to discuss?

_____

7. CARE PREFERENCES & APPOINTMENT GOALS

What would you most like to accomplish during today's visit?

_____

_____

Do you have any questions or concerns you want to make sure we address?

_____

_____

8. INSURANCE & EMERGENCY CONTACT

Insurance Provider: _____

Member/Policy ID: _____

Emergency Contact Name: _____

Relationship: _____ Phone: _____

9. PATIENT ACKNOWLEDGMENT

I confirm that the information I have provided is accurate to the best of my knowledge. I understand that this questionnaire is used to help prepare for my visit and does not replace a conversation with my healthcare professional.

Patient/Guardian Signature: _____

Date: _____

Important: If you are experiencing a medical emergency or symptoms that require immediate attention, seek emergency medical care rather than waiting for your scheduled appointment.