The Office of Leila Rhodes M.D.

General Medical Evaluation

Visit Date	Last Name	First Name	MI	Date of Birth	Height	Weight

Visit Information:

1.	What is the reason for this visit? (Chief Complaint)			
2.	Have you had this before?		◯ **Yes**	◯ **No**
	If so, when?			
3.	When did your symptoms begin?			
4.	Where is the location of the problem?			
5.	Are your symptoms always present or do they come and go?	◯ **always present**	◯ **come and go**	
6.	On a scale of 1-10, rate the severity of your symptoms;1 being mild and 10 being severe.			
7.	Describe your symptoms			
8.	Is there anything that makes your symptoms better?		◯ **Yes**	◯ **No**
	If yes, what have you tried and what were the results?			
9.	Is there anything that makes your symptoms worse?		◯ **Yes**	◯ **No**
	If yes, what happened and what were the results?			
10.	Since the onset of your chief complaint, please select the status of your symptoms?			
	◯ **symptoms are getting better**	◯ **symptoms are getting worse**	◯ **symptoms are staying the same**	

Depression Screening: Important Notice: The information gathered on this questionnaire will remain confidential.

	Over the last 2 weeks, how often have you been bothered by any of the following problems? Please select the option that applies to each feeling.	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1.	Little interest or pleasure in doing things	◯	◯	◯	◯
2.	Feeling down, depressed, or hopeless	◯	◯	◯	◯
3.	Trouble falling or staying asleep, or sleeping too much	◯	◯	◯	◯
4.	Feeling tired or having little energy	◯	◯	◯	◯
5.	Poor appetite or overeating	◯	◯	◯	◯
6.	Feeling bad about yourself or that you are a failure or have let yourself or family down	◯	◯	◯	◯
7.	Trouble concentrating on things, such as reading the newspaper or watching television	◯	◯	◯	◯
8.	Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	◯	◯	◯	◯
9.	Thoughts you would be better off dead, or of hurting yourself in some way	◯	◯	◯	◯
				[For Office Use Only:	0]
10.	If you selected any problems above, how difficult have these problems made it for you to do our work, take care of things at home, or get along with other people?				
	◯ **Not difficult at all**	◯ **Somewhat difficult**	◯ **Very difficult**	◯ **Extremely difficult**	

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