PRE-APPOINTMENT QUESTIONNAIRE

Name: ______________________________ Today's date: ______________

To help us get the most out of today's visit, please answer the following questions:

1. What is your main purpose in coming to our office today? (If you have a new complaint, indicate how long it has been present, what it feels like, what makes it better or worse, and what you are concerned the problem might be.)

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2. Are you experiencing any of the following symptoms in relation to your main concern?

(Answer "yes" by circling the appropriate symptom.)

Constitutional symptoms: fever, weight loss, extreme fatigue

Eyes: double vision, sudden loss of vision

Ears, nose, mouth and throat: sore throat, runny nose, ear pain

Cardiovascular: chest pain, palpitations

Respiratory: cough, wheezing, shortness of breath

Gastrointestinal: nausea, vomiting, abdominal pain, constipation, diarrhea, blood in stools

Genitourinary: irregular menses, vaginal bleeding after menopause, frequent or painful urination, bloody urine, impotence

Skin: rash, changing mole

Neurological: headache, persistent weakness or numbness on one side of the body, falling

Musculoskeletal: joint pain, muscle weakness

Psychiatric: depression, anxiety, suicidal thoughts

Endocrine: excessive thirst, cold or heat intolerance, breast mass

Hematologic: unusual bruising or bleeding, enlarged lymph nodes

Allergic: hay fever

3. Do you have any other concerns? ☐ Yes (list below) ☐ No

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4. Has anything new come up in your family history?

(For example, have any of your blood relatives recently developed a new illness?) ☐ Yes (list below) ☐ No

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5. Have you developed any new drug allergies? ☐ Yes (list below) ☐ No

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6. What do you do for exercise? ______________________________

How long? ______________ How often? ______________

NOTE: Brisk walking for 30 minutes most days is associated with a 30-percent reduction in the risk of heart attacks.

7. How much tobacco do you smoke or chew per day? ______________________

NOTE: It is recommended that you stop using tobacco. We can enroll you in a tobacco-cessation class.

8. How much alcohol do you consume per week? __________

9. How much caffeine do you consume per day? (i.e., coffee, tea, chocolate, soda) ______________

10. What method of birth control do you use?

☐ Not applicable ☐ The pill ☐ Vasectomy ☐ Tubal ligation

☐ Other (specify): ______________________________

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