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.)

___________________________________________________________________________________________________________________________
___________________________________________________________________________________________________________________________
___________________________________________________________________________________________________________________________

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

___________________________________________________________________________________________________________________________
___________________________________________________________________________________________________________________________

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

___________________________________________________________________________________________________________________________

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

___________________________________________________________________________________________________________________________

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): ____________________________________