



PRE-APPOINTMENT QUESTIONNAIRE

Name: _____ 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): _____