



## 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): \_\_\_\_\_