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

   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 relative 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.

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): ______________________________________