

Sick Visit Pre-Appointment Questionnaire

Name: _____

Today's date: __/__/____

Age: _____

Date of Birth: __/__/____

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. Do you have any other concerns you would like addressed today? Yes (list below) No

A.) _____

B.) _____

3. Since your last visit, have you been diagnosed with any new medical conditions or had any new surgeries?

<u>Disease/Surgery</u>	<u>Date Diagnosed/Performed</u>	<u>Disease/Surgery</u>	<u>Date Diagnosed/Performed</u>
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4. Since last visit, have you been in the hospital, at the Emergency Room, or to new physician's office?

<u>Hospital/ER/Office</u>	<u>What were you there for</u>	<u>Date</u>
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5. Do you have any new drug allergies? Yes (list below) No

6. Please list any new medications (over the counter or prescription): None

<u>Name</u>	<u>Dose</u>	<u>How many times a day?</u>
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1. _____

2. _____

3. _____

4. _____

7. Have you had any changes in employment since your last visit? Yes No

If yes, what is your new job? _____

8. How much tobacco do you smoke or chew per day? _____ pack/day

NOTE: It is recommended that you stop using tobacco. WE CAN HELP! Just ask your doctor or nurse.

9. How much alcohol do you drink per week? _____ drinks/week

10. How much caffeine do you consume per day? (i.e., coffee, tea, soda) _____ servings/week

11. What do you do for exercise? _____
How long (minutes/miles)? _____
How often (days/week)? _____

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

12. Has any blood relative been diagnosed with a new medical condition since your last visit?
Yes (list below) No

13. Over the past 2 weeks have you felt little interest or pleasure in doing things?
 Yes No

14. Over the past 2 weeks have you felt down, depressed, or hopeless?
 Yes No

15. Have you received a tetanus shot in the last 10 years? Yes No

16. When was your last Flu shot? _____ years ago Never received

Women Only:

17. When was your last pap smear? ___/___/___ Never done

18. When was your last mammogram? ___/___/___ Never done

Men Older than 50:

19. Have you ever had your prostate checked? Yes No
If yes, which? Blood test Prostate Exam Both Other: _____

Men and Women Older than 50:

20. Have you ever had a colonoscopy? Yes No
If yes, when? ___/___/___
Where was it performed? _____

Men and Women older than 65:

21. Have you ever had a test for brittle bones? (Bone mineral density testing or DEXA) Yes No
If yes, when? ___/___/___

22. Have you had the pneumonia vaccine? Yes No
If yes, when? ___/___/___

23. Have you ever had the shingles vaccine? Yes No
If yes, when? ___/___/___