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PATIENT PRE-APPOINTMENT QUESTIONNAIRE

NAME: ____TODAY'S DATE: ____________________

1. What is your purpose for coming in today? ____

2. Are you experiencing any of the following symptoms? :

Constitutional symptoms: fever, weight loss, extreme fatigue
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
Musculoskeletal: joint pain, muscle weakness

3. Has anything new come up in your family history? Yes/ No (list) ______________________

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4. Have you developed any new drug allergies? Yes/ No (list) ___________________________

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5. Do you feel safe in your current home environment? Yes/ No

6. Are you sexually active? Yes/ No Are your partner/s Men/Women/ Both?

8. Do you smoke cigarettes, vape, recreational drugs, other: ____________ ?

9. List all current medical providers that you see: _____________________________________

1. Have you ever felt that you ought to cut down on your drinking? Yes/No

2. Have people annoyed you by criticizing your drinking or drug use? Yes/No

3. Have you ever felt bad or guilty about your drinking or drug use? Yes/No

4. Have you ever had a drink or used drugs first thing in the morning? Yes/No
To steady your nerves or to get rid of a hangover?

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Give answers 0-3, using scale:
0 = Not at all; 1 = Several days; 2 = More than half the days; 3 = Nearly every day

1. Little interest or pleasure in doing things? ___
2. Feeling down, depressed or hopeless? ___

Provider: ___________