Tracey L. Brennan, M.D. 324 West Ave., Saratoga Springs, NY 12866 Phone: 518-583-0000 Fax: 518-583-6005

PATIENT 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_____**
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, persistence weakness or numbness on one side of body, falling
Musculoskeletal: joint pain, muscle weakness
Psychiatric: depression, anxiety, suicidal thoughts
Endocrine: excessive thirst, cold or heat intolerance, breast mass
Hematological: unusual bruising or bleeding, enlarged lymph nodes
Allergic: hay fever

3. **Has anything new come up in your family history?** □ Yes (list below) □ No

_____

4. **Have you developed any new drug allergies?** □ Yes (list)_____ □ No

5. **What do you do for exercise? _____**How long?_____ How often?_____

6. **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

7. **How much alcohol do you consume per Week ?_____**

8. **How much caffeine do you consume per day?** (i.e, coffee, tea, chocolate, soda)_____

9. **What method of birth control do you use?** □ Not Applicable □ The pill □ Vasectomy □ tubal ligation □ Other_____

10. **For Females: Date of last Mammogram _____Date of Last pap_____**

11. **Please list any recent surgery:_____**

12. **Please list ALL current Medications:_____**

_____

_____

13. **List All current Medical Providers that you currently see._____**

_____

Patient Signature_____Reviewed by:_____Date:_____