Patient Questionnaire

Name:____________________ DOB: ____________ Date: ____________
Drug Allergies: ____

Please complete the following confidential questionnaire to help us better address your health care needs.

1. Do you have any specific concerns you would like to have addressed today? If so please note them below.
   a. ________ d. ________
   b. ________ e. ________
   c. ________ f. ________
2. List all medications (including over the counter medications and herbal supplements) that you are taking. Include dosage and frequency. (Please turn this form over and use the back if more room is needed).
   a. ________ d. ________
   b. ________ e. ________
   c. ________ f. ________
3. Please circle if you have ever been diagnosed with any of the following:

Allergic rhinitis	Diabetes	Glaucoma	High Blood Pressure	Syphilis
Anxiety	Diverticulitis	Gonorrhea	Irritable Bowel Syndrome	Tuberculosis
Arthritis	High Cholesterol	Gout	Kidney Disease/Stones	Ulcers
Asthma	Emphysema	Heart attack	Migraines	Other:
Chlamydia	Epilepsy/seizures	Heart Disease	Osteoporosis	________
Dementia	Gallstones	Hepatitis	Reflux	________
Depression	Genital warts	Herpes	Stroke or "Mini" Stroke	________
Cancer (type) ________				

4. Are you currently under the care of any other physician? If so, please list.
   a. ________ c. ________
   b. ________ d. ________
5. List all operations (including outpatient) and their approximate dates.
   a ________ c. ________
   b. ________ d. ________
6. What type of work do you do? ________

Where appropriate please circle "yes" or "no" for each question.

7. Do you wear glasses or contacts? Yes No Date of last exam: ________
8. Do you, or have you ever, smoked? Yes No
   If yes, packs per day ____ Years:____ Quit:____ When:______
9. Do you drink alcohol? Yes No
   If yes, drinks daily:____ Per Week:____ Quit:____ When:_____
10. Do you use any illegal drugs or have you in the past? Yes No
11. Do you get regular aerobic exercise? Yes No Please Describe________
12. In what year did you get your last tetanus shot? ________
13. Have you ever had the pneumonia vaccine? Yes No
14. Have you ever had a colonoscopy? Yes No If yes, what year was last one? ______
15. Please circle if a blood relative (grandparent, parent, sibling, or child) has ever had any of the following diseases:
    Diabetes High Cholesterol Heart Disease High Blood Pressure
    Other: ________ Cancer (type): ________

For Women Only

a. Have you ever been pregnant? Yes No
   If yes, how many times? ______ Number of children: ______ Date of last menstrual period: ________
b. Are you sexually active? Yes No
   If yes, how many sexual partners do you have? ________ Is (are) your sexual partner(s) male or female? ________
c. Do you use birth control? Yes No
   If yes, what kind?________ Date of last Pap smear? ________
d. Have you ever had an abnormal Pap smear? Yes No
   If yes, when? ________ Date of last mammogram? ________
e. Do you do breast self-examinations? Yes No
f. Have you ever had a bone density scan (DEXA)? Yes No If yes, year of last scan: ________

For Men Only

a. Are you sexually active? Yes No
   If yes, how many sexual partners do you have? ________ Is (are) your sexual partner(s) male or female? ________
b. Do you perform testicular self-examinations? Yes No
c. Have you ever had your PSA checked? Yes No

Please answer the following general questions about your current state of health. If you answer "yes" to any of the questions, please write the corresponding number with an explanation on the back of this page.

General/ Constitutional

1. Have you had a change in weight?.. Yes No
2. Have you had a change in general health?.. Yes No
3. Have you had fevers/ chills/ night sweats? .... Yes No

Skin/ Breast

4. Do you have any concerns about your hair, skin, or nails?.. Yes No
5. Have you noticed any problems with your breasts? .... Yes No

Eyes/ Ears/ Nose/ Mouth/ Throat

6. Do you have frequent or otherwise troubling headaches? .... Yes No
7. Have you had a change in vision? .... Yes No
8. Do you have any difficulty breathing through your nose? .... Yes No
9. Are there any other concerns about eyes, ears, mouth, nose, or throat? .... Yes No

Cardiovascular

10. Do you ever have problems with chest pain? .... Yes No
11. Do you have problems with irregular or fast heart beats? .... Yes No
12. Do you have problems with swelling in your legs? .... Yes No
13. Does walking predictably result in leg pain? .... Yes No

Respiratory

14. Do you have problems with a chronic cough? .... Yes No
15. Have you ever had asthma or been treated with inhalers? .... Yes No
16. Do you ever have difficulty breathing? .... Yes No

Gastrointestinal

17. Do you have heartburn, abdominal pain, or difficulty swallowing? .... Yes No
18. Do you have frequent diarrhea or constipation? .... Yes No
19. Have you had blood in stools or black/ tar like stools? .... Yes No
20. Do you have any other concerns about your digestion? .... Yes No

Genitourinary

21. Do you have problems with frequent urinary infections (UTI)? .... Yes No
22. Do you have difficulty with urinary incontinence or blood in the urine? .... Yes No
23. Do you have problems with initiating a urinary stream or frequent night urination? .... Yes No
24. Do you have any vaginal discharge or itching? .... Yes No
25. Have you had any vaginal bleeding since menopause or lasting longer than 6 months? ... Yes No
26. Are your periods regular? .... Yes No
27. Are you having any physical problems sexually? .... Yes No

Musculoskeletal

28. Do you have pain in any joints or muscles? .... Yes No
29. Do you have any muscle fatigue or weakness? .... Yes No

Neurological/ Psychiatric

30. Have you noted any change in your sensation, strength, or coordination? .... Yes No
31. Are you concerned about memory problems? .... Yes No
32. Is your mood predominantly anxious or depressed? .... Yes No
33. Have you had any falls in the last year? .... Yes No
34. Are you experiencing any stressful issues in your life? (job, finances, marriage, family, etc.) .... Yes No

Beck Depression Inventory

Please answer each question based on how you feel today. Circle the score (0-3) for each of the 21 questions listed below.

1.
   0 I do not feel sad.
   1 I feel sad.
   2 I am sad all the time and I can't snap out of it.
   3 I am so sad and unhappy that I can't stand it.

2.
   0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel the future is hopeless and that things cannot improve.

3.
   0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life, all I can see is a lot of failures.
   3 I feel I am a complete failure as a person.

4.
   0 I get as much satisfaction out of things as I used to.
   1 I don't enjoy things the way I use to.
   2 I don't get real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

5.
   0 I don't feel particularly guilty.
   1 I feel guilty a good part of the time.
   2 I feel quite guilty most of the time.
   3 I fell guilty all the time.

6.
   0 I don't feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7.
   0 I don't feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

8.
   0 I don't feel I am any worse than anybody else.
   1 I am critical of myself for weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. 0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't even though I want to.

11. 0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12. 0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever did.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14. 0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

15. 0 I can work about as well as before.
1 It takes extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16. 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more that fifteen pounds.

20. 0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21. 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely.