

**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.)

**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, 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?** if so, please list below

**4. Has anything new come up in your family history?**  
(For example, have any of your blood relatives recently developed a new illness?)

**5. Have you developed any new drug allergies?** if so, please list below

**6. What do you do for exercise?** \_\_\_\_\_

**7. How much tobacco do you smoke or chew per day?**

**8. How much alcohol do you consume per week?**

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