# Holy Cross Health Network

**NG Pre-Appointment Questionnaire Extended**

**Name:**_____**DOB:** ____/_____/____ **APPT:** _____/_____/_____@_____

*******12 HOUR FAST, WATER AND BLACK COFFEE ONLY. 48 HOURS NO ALCOHOL. *******

**What is the main purpose of your visit today**? _____
How long have you had this problem? _____

Are you a smoker? ☐ Yes, every day ☐ No, have never smoked
☐ Yes, some days ☐ No, I am a former smoker
Are you exposed to passive smoke? ☐ Yes ☐ No
Do you use any other form of tobacco? ☐ Yes ☐ No If yes, what _____

**During the past month**, have you often been bothered by:
1) Little interest or pleasure in doing things ☐ Yes ☐ No 2) Feeling down, depressed or hopeless ☐ Yes ☐ No

**Have you fallen in the last year? ☐ Yes ☐ No **Do you have problems walking or with balance? ☐ Yes ☐ No

**Women**: Last menstrual period? _____ Have you had a pap outside of this office? ☐ Yes ☐ No
If yes, where and date _____

| Please rate your current level of pain. If you have no pain, please choose 0. | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Severe Pain |

| Medication | Dosage |
|---|---|
| | |
| | |
| | |
| | |
| | |

| Allergies | What Reaction Did You Get? |
|---|---|
| | |
| | |
| | |
| | |
| | |

| Surgeries: |
|---|
| |
| |
| |

| Please list any Specialists you are currently seeing: | | | |
|---|---|---|---|
| Doctor: | Phone: | Doctor: | Phone: |
| Doctor: | Phone: | Doctor: | Phone: |

| Diabetics Only: Please answer the following questions regarding your diabetes: | | |
|---|---|---|
| Are you monitoring your blood sugar? | ☐ Yes ☐ No | How Often: (Please bring log sheet to your appointment) |
| Do you drink alcohol? | ☐ Yes ☐ No | Amount Per Week: |
| Have you attended diabetes classes? | ☐ Yes ☐ No | |
| How often are you exercising? | | |
| When was your last dietician visit? | | |

| Date of your last eye exam: | Eye Doctor: | Phone: |
|---|---|---|

**Review of Systems**: Are you experiencing any of the following symptoms IN THE LAST MONTH.

| **Constitutional:** | **Gastrointestinal:** | **Neurological:** | **Hematologic/Lymphatic** |
|---|---|---|---|
| □ Chills<br>□ Fatigue<br>□ Fever<br>□ Malaise (feeling sick)<br>□ Night sweats<br>□ Weight gain<br>□ Weight loss<br>□ Other: | □ Abdominal pain<br>□ Blood in stools<br>□ Change in stools<br>□ Constipation<br>□ Diarrhea<br>□ Heartburn<br>□ Loss of appetite<br>□ Nausea<br>□ Vomiting<br>□ Other: | □ Dizziness<br>□ Arm/leg numbness<br>□ Arm/leg weakness<br>□ Disturbance in gait/walking<br>□ Headaches<br>□ Memory loss<br>□ Seizures<br>□ Tremors<br>□ Other: | □ Easy bleeding<br>□ Easy bruising<br>□ Swelling of lymph nodes<br>□ Other: |
| **HEENT:** | **Genitourinary:** | **Psychiatric:** | **Immunologic:** |
| □ Ear drainage<br>□ Ear pain<br>□ Eye discharge<br>□ Eye pain<br>□ Hearing loss<br>□ Nasal drainage<br>□ Sinus pressure<br>□ Sore throat<br>□ Visual changes<br>□ Other: | □ Pain with urination<br>□ Blood in urine<br>□ Urinating large volumes of clear/dilute urine<br>□ Urinating frequently<br>□ Urinary incontinence<br>□ Urinary retention (inability to urinate)<br>□ Other: | □ Anxiety<br>□ Depression<br>□ Insomnia<br>□ Suicidal thoughts<br>□ Other: | □ Contact allergy (to chemicals, metals, etc)<br>□ Environmental allergies<br>□ Food allergies<br>□ Seasonal allergies<br>□ Other: |
| **Respiratory:** | **Reproductive:** | **Metabolic/Endocrine:** | |
| □ Chronic cough<br>□ Cough<br>□ Known TB exposure<br>□ Shortness of breath<br>□ Wheezing<br>□ Other: | □ Abnormal pap<br>□ Painful periods<br>□ Pain during sexual intercourse<br>□ Hot flashes<br>□ Irregular periods<br>□ Vaginal discharge<br>□ Erectile dysfunction<br>□ Penile discharge<br>□ Sexual dysfunction<br>□ Other: | □ Brittle hair<br>□ Brittle nails<br>□ Hair loss<br>□ Unusual hair growth on face of body<br>□ Hives<br>□ Pruritis (itching)<br>□ Mole/skin changes<br>□ Rash<br>□ Lesions/spots on skin<br>□ Other: | **Please list any other concerns:** |
| **Cardiovascular:** | **Integumentary:** | **Musculoskeletal:** | |
| □ Chest pain<br>□ Claudication (pain in your legs when walking)<br>□ Edema (swelling)<br>□ Palpitations<br>□ Other: | □ Cold intolerance<br>□ Heat intolerance<br>□ Drinking/Eating large amounts of food/water<br>□ Other: | □ Back pain<br>□ Joint pain<br>□ Joint swelling<br>□ Muscle weakness<br>□ Neck pain<br>□ Other: | |

**Medical History**: do **YOU** have a history of (or have been treated for) any of the following?

| Problem | Comments? | Problem | Comments? |
|---|---|---|---|
| □ Anemia | | □ Kidney disease | |
| □ Anxiety | | □ Liver disease | |
| □ Arthritis | | □ Malaria | |
| □ Asthma | | □ Hepatitis | |
| □ Cancer (where? what kind?) | | □ Migraines or Headaches | |
| □ Depression | | □ Osteoporosis | |

| Problem | Comments? | Problem | Comments? |
|---|---|---|---|
| □ Diabetes | | □ Seizures | |
| □ Glaucoma or Cataracts | | □ Stomach problems (reflux?) | |
| □ Heart Disease | | □ Liver problems | |
| □ High blood pressure | | □ Stroke | |
| □ High cholesterol | | □ Swelling | |
| | | □ Thyroid disease | |
| | | □ OTHER medical problems? | |

**Family History**: does anyone **IN YOUR FAMILY** have (or have been treated for) any of the following?

| Problem | Who in your family? | Problem | Who in your family? |
|---|---|---|---|
| □ Alcoholism | | □ Drug Addiction | |
| □ Asthma | | □ Glaucoma | |
| □ Arthritis | | □ Heart Attack (what age?) | |
| □ Bad reaction to Anesthesia | | □ High blood pressure | |
| □ Bleeding disorders | | □ High cholesterol | |
| □ Cancer - Breast | | □ Seizure disorder | |
| □ Cancer - Colon | | □ Stroke | |
| □ Cancer - Prostate | | □ Thyroid disease | |
| □ Cancer – other (where?) | | □ OTHER medical problems in your family? | |
| □ Depression or Anxiety | | | |
| □ Diabetes | | | |

**Social History:**

Are you Currently Employed: ☐ Yes ☐ No Occupation: _____ Education: _____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
# of Children: _____ (WOMEN only) # of Pregnancies _____
Who lives in your household? _____

(1) In the past year, how often did you have an alcohol drink? → If NEVER, skip Questions 2 and 3.
[ ] Never (I never drink alcohol)
[ ] 1 time per month, or less
[ ] 2-4 times a month
[ ] 2-3 times a week
[ ] 4 or more times a week

(2) In the past year, on a typical day that you *did* drink alcohol, how many drinks did you have?
[ ] 1 or 2
[ ] 3 or 4
[ ] 5 or 6
[ ] 7 to 9
[ ] 10 or more

(3) In the past year, how often did you have six or more drinks in the *same day*?
[ ] Never
[ ] Less than monthly
[ ] Monthly
[ ] Weekly
[ ] Daily or almost daily

Have you ever used **recreational drugs** (like marijuana, cocaine, heroin, intravenous drugs)? ☐ Yes ☐ No

Are you very active or get regular **exercise**? ☐Yes ☐ No

Do you have a religious affiliation? ☐ Yes ☐ No (Optional) If yes, what is your affiliation? _____

Do you have **smoke detectors** and check the batteries regularly? ☐ Yes ☐ No
Do you always wear your **seatbelt** when in a motor vehicle? ☐ Yes ☐ No

If you are elderly or handicapped, do you feel your home is designed to prevent injuries? ☐ Yes ☐ No
Do you have problems with **activities of daily living** such as bathing, toileting or fixing meals? ☐ Yes ☐ No

Do you have any **guns/weapons** in the home? ☐ Yes ☐ No
Have you ever been emotionally or physically abused by your partner or someone important to you? ☐ Yes ☐ No
Does your partner ever force you into sex? ☐ Yes ☐ No ☐ Not applicable
Are you afraid of your partner, ex-partner, or someone important to you? ☐ Yes ☐ No ☐ Not applicable