PATIENT STICKER HERE

PRE-APPOINTMENT QUESTIONNAIRE

Patient Name:	D.O.B.

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.)

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2. Have you developed any new drug allergies? ☐ Yes (list below) ☐ No

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3. How much tobacco do you smoke or chew per day? ______________________________

Would you like more information on a tobacco-cessation class? ☐ Yes ☐ No

4. Do you consume alcohol? ☐ Yes (list below) ☐ No. How much? ______________________________

List all medications you are taking (use backside if needed): ______________________________

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5. Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not At All	Several Days	More than Half the days	Nearly Every
A. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
B. Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**

Sleep Disturbance Symptoms ☐ **Refer to Sleep Lab**

1. Have you been told you snore loudly?	Y	N
2. Do you stop breathing at night or wake up feeling short of breath (choking/gasping)?	Y	N
3. Do you fall asleep during the day when sitting still?	Y	N

Allergy Symptoms ☐ **Refer to Allergy Lab**

1. Do you experience any of the following: *(circle all that apply)*

Hayfever Runny Nose Nasal Congestion Sneezing Watery Eyes Itchy Throat Itchy Skin Cough

FEMALE PATIENTS ☐ **Refer to Urodynamics**

1. Do you lose urine while coughing, sneezing, laughing, lifting, jumping, or running?	Y	N
2. Do you experience heavy bleeding during your menstrual cycle lasting more than 7 days?	Y	N
3. Do you experience pelvic pain during your menstrual cycle?	Y	N
4. Do you experience menopausal symptoms, such as hot flashes and/or irritability?	Y	N

☐ **Refer to GYN**