

Diagnostic & Medical Clinic
Pre-Visit Questionnaire: Initial Visit with Dr. Jacob Webster

Today's Date: _____

1. Name: _____

2. Address: _____
(Street) (Apt. Number)

(City) (State) (Zip Code)

3. Phone: () _____

4. What is your date of birth? _____ / _____ / _____
(Month) (Day) (Year)

5. Sex: 1.) _____ Male

2.) _____ Female

6. Who has been your previous primary care doctor?

Name: _____

Address: _____

Phone number: () _____

7. Do you plan to continue to be followed by me as your primary physician?

1.) _____ NO

2.) _____ YES

3.) _____ Not sure

PAST MEDICAL HISTORY

8. Which medical conditions do you have or have you had in the past?
(Check all that apply)

I. EYE & EAR PROBLEMS

- a.) _____ Cataracts
- b.) _____ Glaucoma
- c.) _____ Macular degeneration of the eye
- d.) _____ Hearing loss / hearing aid
- e.) _____ Other, specify: _____

II. HEART PROBLEMS

- a.) _____ Heart attack: Year _____
- b.) _____ Heart failure
- c.) _____ High blood pressure
- d.) _____ Irregular heart beats (Arrhythmias)
- e.) _____ High Cholesterol
- f.) _____ other, specify: _____

III. LUNG PROBLEMS

- a.) _____ Asthma
- b.) _____ Bronchitis
- c.) _____ Emphysema
- d.) _____ Other, specify: _____

IV. BONE & JOINT PROBLEMS

- a.) _____ Arthritis
- b.) _____ Osteoporosis
- c.) _____ Fractured hip, wrist or spine [circle which one(s)]
- d.) _____ Gout
- e.) _____ Other, specify: _____

V. GLAND PROBLEMS

- a.) _____ Diabetes
- b.) _____ Thyroid overactive (high)
- c.) _____ Thyroid underactive (low)
- d.) _____ Other, specify: _____

VI. KIDNEY & URINARY TRACT PROBLEMS

- a.) _____ Kidney disease
- b.) _____ Prostate disease
- c.) _____ Frequent bladder or kidney infections
- d.) _____ Urinary incontinence
- e.) _____ Other, specify: _____

VII. GASTROINTESTINAL PROBLEMS

- a.) _____ Ulcers
- b.) _____ Heartburn / Hiatal hernia
- c.) _____ Diverticulosis
- d.) _____ Liver disease / Cirrhosis
- e.) _____ Hepatitis
- f.) _____ Polyps
- g.) _____ Gallbladder disease
- h.) _____ Other, specify: _____

VIII. NERVOUS SYSTEM PROBLEMS

- a.) _____ Stroke
- b.) _____ Dementia or Alzheimer's Disease
- c.) _____ Parkinson's Disease
- d.) _____ Epilepsy or Seizures
- e.) _____ Other, specify: _____

IX. OTHER HEALTH PROBLEMS

a.) _____ Allergies, specify: _____

b.) _____ Anemia

c.) _____ Hernia

d.) _____ Thrombosis

e.) _____ Cancer, of what: _____

f.) _____ Depression

g.) _____ Sexual function problems, specify: _____

h.) _____ Other, specify: _____

9. List Surgeries (Operations)

DATE	SURGERIES (OPERATIONS)
_____	_____
_____	_____
_____	_____
_____	_____

10. List Other Hospitalizations

DATE	REASON
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY

13. With whom do you live? (check one)

- 1.) _____ Alone
- 2.) _____ Spouse or partner
- 3.) _____ Child or other family member
- 4.) _____ Others, not family

14. Are you currently (check one)

- 1.) _____ Married
- 2.) _____ Divorced / Separated
- 3.) _____ Widowed
- 4.) _____ Single / Never married
- 5.) _____ Living with Significant Other

15. How many children do you have? _____

16. How much school did you complete? (check one)

- 1.) _____ Less than 6th grade
- 2.) _____ Less than high school graduate
- 3.) _____ High school graduate
- 4.) _____ Some college
- 5.) _____ College graduate
- 6.) _____ More than college graduate

17. Are you currently (check one)

- 1.) _____ Retired / Not working
- 2.) _____ Working part-time
- 3.) _____ Working full-time

18. What has been your principal occupation?

19. Do you drink alcohol, including beer, wine or other such as vodka, whiskey or gin?

- 1.) _____ Daily
- 2.) _____ Almost daily
- 3.) _____ 1 to 3 times a week
- 4.) _____ Less than 1 time per week
- 5.) _____ Never

20. If you drink alcohol, has anyone ever been concerned about your drinking?

- 1.) _____ NO
- 2.) _____ YES

21. Have you ever smoked cigarettes?

- 1.) _____ NO
- 2.) _____ YES If yes, are you now smoking?
 - a.) _____ No If No,
 1. How many years ago did you quit? _____
 2. For how many years did you smoke? _____
 3. How much did you smoke? _____ packs per day
 - b. _____ Yes If Yes,
 1. How many years have you smoked? _____
 2. How much do you smoke? _____ packs per day

FAMILY HISTORY

22. Have any members of your family had any of the following conditions? (Check all that apply)

- 1.) _____ Cancer, of what? _____
 - 2.) _____ Heart disease
 - 3.) _____ Stroke
 - 4.) _____ Diabetes
 - 5.) _____ Depression
 - 6.) _____ Other Chronic or Inherited Illnesses, please specify:
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PLANNING FOR FUTURE HEALTH CARE

23. Do you have a medical Durable Power of Attorney? Do you have a living will?

- 1.) _____ NO
- 2.) _____ YES (if yes, please bring a copy)

Review of Systems: To be certain that we've covered everything, during the last three months, have you had any of the following symptoms / problems? (Check all that apply)

I. GENERAL PROBLEMS

- a.) _____ Weight loss
- b.) _____ Weight gain
- c.) _____ Fevers
- d.) _____ Chills
- e.) _____ Sweats
- f.) _____ Cold or flu
- g.) _____ Change of appetite

II. EYES

- a.) _____ Trouble seeing
- b.) _____ Eye pain
- c.) _____ Dry eyes

III. EAR, NOSE, MOUTH THROAT

- a.) _____ Trouble hearing
- b.) _____ Ear pain or itching
- c.) _____ Sinus problems
- d.) _____ Nose bleeds
- e.) _____ Sore throat
- f.) _____ Teeth problems
- g.) _____ Hoarseness
- h.) _____ Mouth sores
- i.) _____ Allergies

IV. HEART PROBLEMS

- a.) _____ Chest pain or tightness
- b.) _____ Rapid or irregular heartbeat
- c.) _____ Swelling of feet

V. LUNG PROBLEMS

- a.) _____ Persistent cough
- b.) _____ Difficulty breathing or shortness of breath
- c.) _____ Coughing up blood
- d.) _____ Wheezing

VI. DIGESTIVE PROBLEMS

- a.) _____ Difficulty swallowing
- b.) _____ Frequent indigestion or stomach ache, heartburn
- c.) _____ Frequent nausea or vomiting
- d.) _____ Change in bowel habits
- e.) _____ Black bowel movement or bleeding from rectum
- f.) _____ Frequent diarrhea
- g.) _____ Persistent constipation

VII. BONE AND JOINT PROBLEMS

- a.) _____ Leg pain on walking
- b.) _____ Back or neck pain
- c.) _____ Joint pain or stiffness
- d.) _____ Foot problems
- e.) _____ Falls

VIII. BRAIN AND NERVOUS SYSTEM PROBLEMS

- a.) _____ Frequent headaches
- b.) _____ Frequent dizzy spells
- c.) _____ Passing out or fainting

- d.) _____ Falls
- e.) _____ Paralysis, leg or arm weakness
- f.) _____ Numbness or loss of feelings
- g.) _____ Serious problem with memory or difficulty thinking
- h.) _____ Tremor or shaking
- i.) _____ Problems with sleep

IX. MOOD / SADNESS PROBLEMS

- a.) _____ Depression
- b.) _____ Anxiety

X. GYNECOLOGY PROBLEMS

- a.) _____ Vaginal bleeding
- b.) _____ Breast lumps
- c.) _____ Vaginal discharge

XI. KIDNEY & URINARY TRACT PROBLEMS

- a.) _____ Urination at night (How many times) _____
- b.) _____ Frequent or painful urination
- c.) _____ Loss of urine or getting wet. If yes, 6 or more times last year? _____
- d.) _____ Difficulty starting or stopping urination

XII. SKIN PROBLEMS

- a.) _____ Rash
- b.) _____ Sores
- c.) _____ Itching

XIII. MISCELLANEOUS

- a.) _____ Excessive thirst
- b.) _____ Feel too hot or too cold
- c.) _____ Problems with sexual function

HEALTH MAINTENANCE

24. Have you ever had an examination of your bowel with a scope?

(circle which one: sigmoidoscopy or colonoscopy)

1.) _____ NO

2.) _____ YES If YES, when did you have your most recent sigmoidoscopy or colonoscopy? (Circle which one) Year: _____

25. Have you had an eye exam within the past year? Yes _____ No _____

26. Have you ever had elevated cholesterol or triglycerides? YES _____ No _____

27. In the past 12 months, have you had a test for blood in your stool (3 cards at home)?

28. Have you ever had the Pneumovax vaccine (a shot to prevent pneumonia)?

1.) _____ NO

2.) _____ YES If YES, in what year did you have your last Pneumovax vaccine ? _____ year

29. Have you ever had a tetanus shot?

1.) _____ NO

2.) _____ YES If YES, in what year did you have your last tetanus booster? _____ year

30. Have you had a flu shot this season (October – February)?

1.) _____ NO

2.) _____ YES

3.) _____ Not applicable (March-September)

31. Do you always wear a seatbelt when you ride in a car?

1.) _____ NO

2.) _____ YES

32. Do you currently participate in any regular activity to improve or maintain your physical fitness? (either on your own or in a formal class)

1.) _____ NO

2.) _____ YES If YES, list what you do currently _____

Men proceed to question 33; women skip to question 35.

QUESTIONS FOR MEN ONLY

33. Have you ever had a prostate exam (rectal exam)?

1.) _____ NO

2.) _____ YES If YES, when did you have your most recent prostate exam? _____ year

34. Have you ever had a blood test to look for cancer of the prostate (PSA)?

1.) _____ NO

2.) _____ YES If YES, when _____ year

QUESTIONS FOR WOMEN ONLY

35. Have you had a physician perform a clinical breast exam in the last year?

1.) _____ NO, Do you perform a monthly self-breast exam (SBE)? Yes _____ No _____

2.) _____ YES

36. have you ever had a mammogram?

1.) _____ NO

2.) _____ YES If YES, have you had a mammogram within the last year?

a.) _____ No

b.) _____ Yes Month / year _____ / _____

37. Have you had a hysterectomy (surgical removal of the uterus)?

1.) _____ YES

2.) _____ NO If NO, have you ever had a Pap smear / pelvic examination?

a.) _____ no

b.) _____ yes If yes, when was your last Pap smear?

Month / year _____ / _____