BRADLEY-POLK
WALK-IN CLINIC

Pre-Visit Questionnaire: Initial Visit

Today's Date: _____

Name: _____

Who has been your previous primary doctor?

Name: _____

List all other doctors that you are seeing on a regular basis

1.
2.
3.

PAST MEDICAL HISTORY

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

EYE & EAR PROBLEMS

a) Cataracts
b) Glaucoma
c) Macular degeneration of the eye
d) Hearing loss/Hearing aid
e) Other, specify?

HEART PROBLEMS

a) Heart attack: Year?
b) Heart failure
c) High blood pressure
e) High cholesterol
f) Other, specify?

LUNG PROBLEMS

a) Asthma
b) Bronchitis
c) Emphysema
d) Other, Specify:

BONE & JOINT PROBLEMS

a) Arthritis
b) Osteoporosis
c) Fractured hip, wrist or spine (circle which one)
d) Gout
e) Other, Specify:

GLAND PROBLEMS

a) Diabetes
b) Thyroid
c) Other, Specify:

KIDNEY & URINARY TRACT PROBLEMS

a) Kidney disease
b) Prostate disease
c) Frequent bladder or kidney infections
d) Urinary incontinence
e) Other, Specify:

GASTROINTESTINAL PROBLEMS

a) Ulcers
b) Heartburn/Hiatal hernia
c) Diverticulosis
d) Liver disease/Cirrhosis
e) Hepatitis
f) Polyps
g) Other, Specify:

NERVOUS SYSTEM PROBLEMS

a)Stroke
b)Dementia or Alzheimer's Disease
c) Parkinson's Disease
d) Epilepsy or Seizures
e) Other, Specify:

OTHER HEALTH PROBLEMS

a) Allergies, specify:
b)Anemia
c) Hernia
d) Thrombosis (blood clots)
e) Cancer, Specify:
f) Depression
g) Sexual function problems, Specify:

List Surgeries (Operations). Use back of page, if needed.

DATE/SURGERY (OPERATIONS)

List Other Hospitalizations. Use back of page, if needed.

DATE/REASON

Do you have any **DRUG ALLERGIES**? If YES, specify below.

_____ _____
NO YES

NAME OF DRUG AND REACTION

List **ALL** medications that you use (Prescriptions, Non-Prescriptions, Natural Products)

SOCIAL HISTORY

With whom do you live? (Circle one)

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

Are you currently (circle one)

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

How many children do you have? _____

Are you currently (Circle one)

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

Do you drink alcohol? (If Yes, then how much)

1) NO
2) YES _____

History of Recreational Drug Use?

Have you ever smoked cigarettes or use of other tobacco products? (Circle one)

1) NO
2) YES....If **YES**, Are you now smoking or using tobacco products?
   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

List details of your family history

Father (Alive/Deceased)
Mother (Alive/Deceased)
Brothers (Alive/Deceased)
Sisters (Alive/Deceased)

Is there any family history of Cancer? _____

To be certain that we've covered everything, *during the last three months*, have you had any of the following symptoms or problems? (Circle all that apply)

GENERAL PROBLEMS

a) Weight Loss
b) Weight Gain
c) Fevers
d) Chills
e) Sweats
f) Cold or Flu
g) Change in Appetite

EYES

a) Trouble seeing
b) Eye Pain
c) Dry Eyes

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

HEART PROBLEMS

a) Chest pain or tightness
b) Rapid or irregular heart beat
c) Swelling of feet

LUNG PROBLEMS

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

DIGESTION 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

BONE AND JOINT PROBLEMS

a) Back or neck pain
b) Joint pain or stiffness
c) Foot problems
d)Falls

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 feeling
g) Serious problem with memory or difficulty thinking
h) Tremor or shaking
I) Problems with sleep

MOOD/SADNESS PROBLEMS

a) Depression
b) Anxiety
c) Other _____

GYNECOLOGY PROBLEMS

a) Vaginal bleeding
b) Breast lumps or discomfort
c) Vaginal discharge

KIDNEY & URINARY TRACT PROBLEMS

a) Urination at night (How many times)_____
b) Frequent urination
c) Painful urination
d) Difficulty starting or stopping urination
e) Loss of urine or getting wet. (6 or more times in the last year)___yes____no

SKIN PROBLEMS

a) Rash
b) Sores
c) Itching

MISCELLANEOUS

a) Excessive thirst
b) Feet too hot or too cold
c) Problems with sexual function

If you have had none of the above problems listed in question 25 during the *past 3 months*, check here _____

HEALTH MAINTENANCE

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 _____

Have you had a hearing test within the last two years? _____YES_____NO

In the past 12 months, have you had

1) NO
2) YES

Which vaccinations have you had? (Circle all that apply)

Flu Vaccine
Pneumonia Vaccine
Tetanus Vaccine
Whooping Cough Vaccine
Shingles Vaccine
Hepatitis Vaccine
Other _____

QUESTIONS FOR "MEN" ONLY

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 _____

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

1) NO
2) YES...If YES, when did you have your most recent blood test to look for prostate cancer?

QUESTIONS FOR "WOMEN" ONLY

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 _____

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? ____YES___NO
3) If YES, when was your last Pap smear? Month/Year _____

Do you have any other health problems that you would like your doctor to know about before your visit?

Signature: _____

Date: _____

THANK YOU FOR COMPLETING THIS FORM.