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.

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<th>DATE/SURGERY (OPERATIONS)</th>
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List Other Hospitalizations. Use back of page, if needed.

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

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<th>NO</th>
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<th>NAME OF DRUG AND REACTION</th>
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List **ALL** medications that you use (Prescriptions, Non-Prescriptions, Natural Products)

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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.