



PRECONSULTATION HEALTH QUESTIONNAIRE

Name of Patient: _____ Date: _____

Please answer the following questions:

- | | Yes | No | | Yes | No | | |
|-----|--------------------------|--------------------------|--|-----|--------------------------|--------------------------|---|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Are you physically active? | 22. | <input type="checkbox"/> | <input type="checkbox"/> | If yes, has it increased? |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Are you troubled with pain in any of your joints? | 23. | <input type="checkbox"/> | <input type="checkbox"/> | If yes, has it decreased? |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | If yes, is it worse in the night? | 24. | <input type="checkbox"/> | <input type="checkbox"/> | Has your weight changed more than ten pounds in the last year? |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Do your joints ever swell? | 25. | <input type="checkbox"/> | <input type="checkbox"/> | Are you troubled with frequent loose bowel movements? |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Do you wake up with stiffness or aching in your joints or muscles? | 26. | <input type="checkbox"/> | <input type="checkbox"/> | Are you troubled with constipation? |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Are you troubled by waking in the early hours and being unable to go to sleep again? | 27. | <input type="checkbox"/> | <input type="checkbox"/> | Have you noticed any blood or mucus in your movements? |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have difficulty in going to sleep? | 28. | <input type="checkbox"/> | <input type="checkbox"/> | Are you troubled with irritation, itching or burning around the back passage? |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | Do you suffer with backache? | 29. | <input type="checkbox"/> | <input type="checkbox"/> | Are you troubled with hemorrhoids? |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | If yes, is this ever accompanied by pain down one or both legs? | 30. | <input type="checkbox"/> | <input type="checkbox"/> | Do you suffer with shortness of breath on exertion? |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Is this ever aggravated by coughing or sneezing? | 31. | <input type="checkbox"/> | <input type="checkbox"/> | Are you troubled by pain or tightness in your chest on exertion? |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | Do you get neck pain? | 32. | <input type="checkbox"/> | <input type="checkbox"/> | If yes, is it relieved by resting? |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> | Does it radiate to shoulder, arm or hand? | 33. | <input type="checkbox"/> | <input type="checkbox"/> | Do you suffer with a cramp-like pain in either leg when walking? |
| 13. | <input type="checkbox"/> | <input type="checkbox"/> | Do you get any numbness or tingling in your arms, hands, legs or feet? | 34. | <input type="checkbox"/> | <input type="checkbox"/> | If yes, do you have to stop or slow down to relieve it? |
| 14. | <input type="checkbox"/> | <input type="checkbox"/> | Do you experience any abnormal noises in your ears or head? | 35. | <input type="checkbox"/> | <input type="checkbox"/> | Are you subject to blackout, dizzy spells, or faints? |
| 15. | <input type="checkbox"/> | <input type="checkbox"/> | Are you often troubled by headaches? | 36. | <input type="checkbox"/> | <input type="checkbox"/> | Are you troubled with frequent or persistent cough? |
| 16. | <input type="checkbox"/> | <input type="checkbox"/> | If yes, are they throbbing and accompanied by sickness? | 37. | <input type="checkbox"/> | <input type="checkbox"/> | If yes, is there a lot of phlegm? |
| 17. | <input type="checkbox"/> | <input type="checkbox"/> | Are you troubled with pain or aching in your stomach? | 38. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any pain or difficulty on passing water? |
| 18. | <input type="checkbox"/> | <input type="checkbox"/> | If yes, is it relieved by eating? | 39. | <input type="checkbox"/> | <input type="checkbox"/> | Are you passing water more frequently lately? |
| 19. | <input type="checkbox"/> | <input type="checkbox"/> | If yes, is it relieved by drinking milk? | 40. | <input type="checkbox"/> | <input type="checkbox"/> | Have you any lumps, cysts, or unusual swelling anywhere on your body? |
| 20. | <input type="checkbox"/> | <input type="checkbox"/> | If yes, does it often wake you at night? | 41. | <input type="checkbox"/> | <input type="checkbox"/> | Have you visited a subtropical or tropical country in the last year? |
| 21. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any persistent change in your appetite during the last three months? | 42. | <input type="checkbox"/> | <input type="checkbox"/> | Are you easily depressed? |

Women's Questionnaire

- | | Yes | No | |
|-----|--------------------------|--------------------------|--|
| 43. | _____ | | How many days is it since the first day of your last menstrual period? |
| 44. | <input type="checkbox"/> | <input type="checkbox"/> | Are your periods regular? |
| 45. | <input type="checkbox"/> | <input type="checkbox"/> | Slightly irregular? |
| 46. | <input type="checkbox"/> | <input type="checkbox"/> | Very irregular? |
| 47. | <input type="checkbox"/> | <input type="checkbox"/> | Have they ceased? |
| 48. | <input type="checkbox"/> | <input type="checkbox"/> | Are you taking a contraceptive pill? |
| 49. | <input type="checkbox"/> | <input type="checkbox"/> | Have you an intrauterine contraceptive device fitting in the uterus? |
| 50. | <input type="checkbox"/> | <input type="checkbox"/> | Are your periods accompanied by lower abdominal pain or discomfort? |
| 51. | <input type="checkbox"/> | <input type="checkbox"/> | If yes, is the pain of only moderate severity? |
| 52. | <input type="checkbox"/> | <input type="checkbox"/> | Severe (do you take pain relievers)? |
| 53. | <input type="checkbox"/> | <input type="checkbox"/> | Severe and incapacitating (do you go to bed)? |
| 54. | <input type="checkbox"/> | <input type="checkbox"/> | Do you notice bleeding between period times? |
| 55. | <input type="checkbox"/> | <input type="checkbox"/> | If your periods have stopped completely, have you since had any bleeding from the front passage? |
| 56. | <input type="checkbox"/> | <input type="checkbox"/> | Have you experienced any recent vaginal discharge? |
| 57. | <input type="checkbox"/> | <input type="checkbox"/> | Have you any children? If yes, what ages _____ |
| 58. | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any gynecological or abdominal operations? |
| 59. | <input type="checkbox"/> | <input type="checkbox"/> | Does coughing, straining, or laughing make you pass water? |
| 60. | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any discomfort on, or frequency of passing water? |
| 61. | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been treated for a urinary infection? |
| 62. | <input type="checkbox"/> | <input type="checkbox"/> | Have you a lump in either breast? |