Northwell General and GI Surgery

Returning Patient Questionnaire:

Please complete this questionnaire and bring it with you to your appointment with the practitioner. This information will assist us in your care plan. Thank you.

Full Name: _____ **Date of Birth:** _____

What are you here for today? _____

Please indicate if you **are now experiencing or in the past year experienced** any of the symptoms listed below.

GENERAL
___ Weight Gain
___ Weight Loss
___ Fever
___ Chills
___ Night Sweats
___ Fatigue

HEAD, EARS, EYES, NOSE, THROAT
_____ Eye Pain
_____ Red Eyes
_____ Dry Eyes
_____ Vision Problems
_____ Trouble Swallowing
_____ Pain with Swallowing
_____ Hearing Loss
_____ Nose Bleeds
_____ Dry Mouth
_____ Sore Throat
_____ Hoarseness
____ Swollen Nodes

CARDIO-VASCULAR
_____ Chest Pain
_____ Palpitations
_____ Light Headedness
_____ Leg pain with exercise
_____ Leg swelling

RESPIRATORY
_____ Shortness of Breath
_____ Wheezing
_____ Cough
_____ Painful Breathing
____ Shortness of breath
With activity
____ Sleep Apnea

GASTRO-INTESTINAL
_____ Abdominal Pain
_____ Heartburn/Reflux
_____ Nausea/Vomiting
_____ Hernia
_____ Constipation
_____ Diarrhea

RENAL/REPRODUCTIVE
____ Painful Urination
_____ incontinence
_____ Vaginal Discharge
_____ Abnormal Vaginal Bleeding

MUSCULOSKELETAL
_____ Joint Pain
_____ Joint Stiffness
_____ Back Pain
_____ Muscle Pain
_____ Muscle Weakness

SKIN
____ Rashes
_____ Skin wound

NEUROLOGIC
_____ Confusion
_____ Dizziness
_____ Fainting
_____ Difficulty walking

PSYCH
_____ Suicidal
_____ Insomnia
_____ Anxiety
_____ Depression

ENDOCRINE
_____ Bulging eyes
_____ Hot Flashes
_____ Muscle Weakness
_____ Voice Change

HEME
____ Easy Bleeding
_____ Easy Bruising
____ Swollen Glands

Please indicate any new illnesses or medical history:

_____

_____

_____

Do you have pain that interferes with your daily activity? No Yes

If yes, where is the pain? _____

Please circle the number that represents your pain level:

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

Medications and Supplements: □ Check if no changes

Medication/Supplement	Dosage & Frequency	Reason

Do you exercise regularly? □ Yes □ No
Types of exercise? □ Strengthening □ Cardio Other:_____
How often?_____ times/week _____times/month
If no, what prevents you from exercising? Time Work Health Other: _____

Do you have any other health concerns today?

_____
_____
_____