

# PATIENT QUESTIONNAIRE

NAME: \_\_\_\_\_ SEX:  Male  Female AGE: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

## MARITAL STATUS

- Married
- Widowed
- Separated
- Divorced
- Never married

## YOUR BACKGROUND

- Black (not Hispanic)
- Hispanic
- White (not Hispanic)
- Asian
- Other Describe: \_\_\_\_\_

## HOW FAR YOU WENT IN SCHOOL

- 8th grade or less
- Some high school
- High school graduate or equivalency (GED)
- Some college or associate degree
- Completed college

**INSTRUCTIONS:** This questionnaire will help your doctor better understand problems that you may have. Your doctor may ask you more questions about some of these items. Please make sure to check a box for every item.

During the <b>PAST MONTH</b> , have you <b>OFTEN</b> been bothered by...				During the <b>PAST MONTH</b> ...				
	YES	No		YES	No		YES	No
1. stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	12. constipation, loose bowels, or diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	22. have you had an anxiety attack (suddenly feeling fear or panic)	<input type="checkbox"/>	<input type="checkbox"/>
2. back pain	<input type="checkbox"/>	<input type="checkbox"/>	13. nausea, gas, or indigestion	<input type="checkbox"/>	<input type="checkbox"/>	23. have you thought you should cut down on your drinking of alcohol	<input type="checkbox"/>	<input type="checkbox"/>
3. pain in your arms, legs, or joints (knees, hips, etc)	<input type="checkbox"/>	<input type="checkbox"/>	14. feeling tired or having low energy	<input type="checkbox"/>	<input type="checkbox"/>	24. has anyone complained about your drinking	<input type="checkbox"/>	<input type="checkbox"/>
4. menstrual pain or problems	<input type="checkbox"/>	<input type="checkbox"/>	15. trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	25. have you felt guilty or upset about your drinking	<input type="checkbox"/>	<input type="checkbox"/>
5. pain or problems during sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	16. the thought that you have a serious undiagnosed disease	<input type="checkbox"/>	<input type="checkbox"/>	26. was there ever a single day in which you had five or more drinks of beer, wine, or liquor	<input type="checkbox"/>	<input type="checkbox"/>
6. headaches	<input type="checkbox"/>	<input type="checkbox"/>	17. your eating being out of control	<input type="checkbox"/>	<input type="checkbox"/>	Overall, would you say your health is:		
7. chest pain	<input type="checkbox"/>	<input type="checkbox"/>	18. little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	Excellent <input type="checkbox"/>		
8. dizziness	<input type="checkbox"/>	<input type="checkbox"/>	19. feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	Very good <input type="checkbox"/>		
9. fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	20. "nerves" or feeling anxious or on edge	<input type="checkbox"/>	<input type="checkbox"/>	Good <input type="checkbox"/>		
10. feeling your heart pound or race	<input type="checkbox"/>	<input type="checkbox"/>	21. worrying about a lot of different things	<input type="checkbox"/>	<input type="checkbox"/>	Fair <input type="checkbox"/>		
11. shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>				Poor <input type="checkbox"/>		