

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.

<i>During the PAST MONTH, have you OFTEN been bothered by...</i>			<i>During the PAST MONTH...</i>		
	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"/>
2. back pain	<input type="checkbox"/>	<input type="checkbox"/>	13. nausea, gas, or indigestion	<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"/>
4. menstrual pain or problems	<input type="checkbox"/>	<input type="checkbox"/>	15. trouble sleeping	<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"/>
6. headaches	<input type="checkbox"/>	<input type="checkbox"/>	17. your eating being out of control	<input type="checkbox"/>	<input type="checkbox"/>
7. chest pain	<input type="checkbox"/>	<input type="checkbox"/>	18. little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>
8. dizziness	<input type="checkbox"/>	<input type="checkbox"/>	19. feeling down, depressed, or hopeless	<input type="checkbox"/>	<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"/>
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"/>
11. shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>			
			22. have you had an anxiety attack (suddenly feeling fear or panic)	<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"/>
			24. has anyone complained about your drinking	<input type="checkbox"/>	<input type="checkbox"/>
			25. have you felt guilty or upset about your drinking	<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"/>
			Overall, would you say your health is:		
			Excellent	<input type="checkbox"/>	
			Very good	<input type="checkbox"/>	
			Good	<input type="checkbox"/>	
			Fair	<input type="checkbox"/>	
			Poor	<input type="checkbox"/>	