

**COLUMBUS INTERNAL MEDICINE  
ESTABLISHED PATIENT QUESTIONNAIRE**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**What is the reason for your visit today?** \_\_\_\_\_

*\*If you are here for a Preventative, or 'Well Visit', and more than two diagnosis or problems are listed and addressed, your visit will not be considered or billed as a preventative or well visit and you will be asked to make another appointment for your preventative or well visit for another date. We will not change diagnosis codes after your claim has been submitted to your insurance company in order to qualify your visit as a preventative exam if you were seen for two or more problems as stated previously.*

**Please list your current medications and check the box if you need REFILLS today OR WILL NEED THEM in the near future:**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Social History**

- Do you use Alcohol? If yes, list average amount per week      No      Yes \_\_\_\_\_ / week
- Do you use tobacco? If yes, list type/amount/how long      No      Yes \_\_\_\_\_ type / \_\_\_\_\_ amount / \_\_\_\_\_ how long
- Do you use recreational drugs? If yes, list type / amount      No      Yes \_\_\_\_\_ type / \_\_\_\_\_ amount
- Do you have a particular diet? If yes, list type of diet      No      Yes \_\_\_\_\_
- Do you use Caffeine? If yes, list type / amount      No      Yes \_\_\_\_\_ type(s) / \_\_\_\_\_ amount per day
- Do you have any recent lifestyle changes? If yes,  
Please list type of change (ex., marriage, job change, etc.)      No      Yes \_\_\_\_\_
- Do you exercise? If yes, list what kind of exercise      No      Yes \_\_\_\_\_
- What is your occupation? How many hours do you work? \_\_\_\_\_ job / \_\_\_\_\_ hrs per week  
Any known exposures from your job/activities?      No      Yes \_\_\_\_\_ type  
What is your spouse's occupation? \_\_\_\_\_

Do you wear a seat belt?      No      Yes

**Since your last Physical Examination have you had:**

- Any recent surgeries? If yes, please list type and date      No      Yes \_\_\_\_\_
- Any changes in family history? If yes, please list      No      Yes \_\_\_\_\_

**ADVANCE DIRECTIVES**

- Do you have a living will?      No      Yes
- Copy of living will at our office?      No      Yes
- Are you an Organ Donor?      No      Yes
- Do you have Power of Attorney for HEALTHCARE?      No      Yes

*-If 'yes', please write their name and relationship to you on the line below:*

\_\_\_\_\_  
Name of POA for Healthcare      Relationship

Patient Name: \_\_\_\_\_

**REVIEW OF SYSTEMS:** Are you experiencing any of the following TODAY? Please circle your response 'No' or 'Yes'

General / Constitutional Symptoms

Fever NO YES  
Chills NO YES

Skin

Rash NO YES  
New Lesion(s) NO YES  
Change in Moles NO YES

Eyes

Blurred Vision NO YES  
Changes in Vision NO YES

Ears

Ear Pain NO YES  
Difficulty Hearing NO YES

Nose

Nasal Congestion NO YES  
Nasal Discharge NO YES  
Nasal Bleeding NO YES

Mouth / Throat

Mouth Pain NO YES  
Neck Pain NO YES  
Neck Swelling NO YES  
Throat Pain NO YES  
Throat Swelling NO YES

Respiratory

Shortness of breath NO YES  
Cough NO YES  
Wheezing NO YES

Cardiovascular

Palpitations NO YES  
Chest Pain NO YES  
Swelling in Extremities NO YES  
Fainting NO YES  
Leg Cramps with walking NO YES

Genitourinary

Painful Urination NO YES  
Frequency with Urination NO YES  
Urgency with Urination NO YES  
Hesitancy with Urination NO YES

Gastrointestinal

Nausea NO YES  
Vomiting NO YES  
Diarrhea NO YES  
Constipation NO YES  
Abdominal Pain NO YES  
Rectal Bleeding NO YES  
Blood in Stool NO YES

Musculoskeletal

Joint Pain NO YES  
Muscle Pain NO YES  
Back Pain NO YES

Neurological

Localized Numbness NO YES  
Weakness NO YES  
Tingling NO YES  
Headaches NO YES

Endocrine

Fatigue NO YES  
Heat Intolerance NO YES  
Cold Intolerance NO YES  
Weight Loss NO YES  
Weight Gain NO YES  
Increasing Thirst NO YES

Hematologic

Easy Bruising NO YES  
Easy Bleeding NO YES  
Oral Ulcerations NO YES  
Recurrent Infections NO YES  
Have you ever had a blood transfusion NO YES

Psychiatric

Depression NO YES  
Anxiety NO YES  
Substance Abuse NO YES  
Suicide Attempts NO YES

Do you have problems sleeping? NO YES

How many hours per night do you usually sleep? \_\_\_\_\_

**\* Females – please answer this section**

Date of last Menstrual Period \_\_\_\_\_  
Date of last Pap Smear Test \_\_\_\_\_  
Date of last Pelvic Exam \_\_\_\_\_  
Date of last Mammogram \_\_\_\_\_

Are you sexually active? NO YES  
Are you using birth control? NO YES  
If yes, please specify type \_\_\_\_\_

Are you pregnant or could you be pregnant? NO YES  
Are you nursing? NO YES