PRIME-MD Patient Questionnaire

Name:_____ Today's Date: _____

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 **PAST MONTH**, have you **OFTEN** been bothered by…*

	Yes	No
1. Stomach pain	☐	☐
2. Back pain	☐	☐
3. Pain in your arms, legs, or joints (knees, hips, etc)	☐	☐
4. Menstrual pain or problems	☐	☐
5. Pain or problems during sexual intercourse	☐	☐
6. Headaches	☐	☐
7. Chest pain	☐	☐
8. Dizziness	☐	☐
9. Fainting spells	☐	☐
10. Feeling your heart pound or race	☐	☐
11. Shortness of breath	☐	☐
12. Constipation, loose bowels, or diarrhea	☐	☐
13. Nausea, gas, or indigestion	☐	☐
14. Feeling tired or having low energy	☐	☐
15. Trouble sleeping	☐	☐
16. The thought that you have a serious undiagnosed disease	☐	☐
17. Your eating being out of control	☐	☐
18. Little interest or pleasure in doing things	☐	☐
19. Feeling down, depressed, or hopeless	☐	☐
20. "Nerves" or feeling anxious or on edge	☐	☐
21. Worrying about a lot of different things	☐	☐

*During the **PAST MONTH**…*

	Yes	No
22. Have you had an anxiety attack (suddenly feeling fear or panic)	☐	☐
23. Have you thought you should cut down on your drinking of alcohol	☐	☐
24. Has anyone complained about your drinking	☐	☐
25. Have you felt guilty or upset about your drinking	☐	☐
26. Was there ever a single day in which you had 5 or more drinks of beer, wine, or liquor	☐	☐

Overall, would you say your health is:

- Excellent ☐
- Very good ☐
- Good ☐
- Fair ☐
- Poor ☐