

FLU / COLD PRE-APPOINTMENT QUESTIONNAIRE Your Name: _____ DOB: _____
 (Glacier Medical Associates, Dr. Bergland – updated 13 Sep 2010)

In order to make the most of your clinic visit, please take a few moments to answer the following questions.

Please describe this acute illness:

How long ago did these symptoms start? _____ days

How severe is your discomfort? Pain scale: 1 (mild) 2 3 4 5 6 7 8 9 10 (severe)

What symptoms have you had during this illness?

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> FEVER | <input type="checkbox"/> COUGH | <input type="checkbox"/> SORE THROAT |
| <input type="checkbox"/> Difficulty breathing / Shortness of breath | | |
| <input type="checkbox"/> Chest pain / pressure | <input type="checkbox"/> Dizziness | |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Vomiting | |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Body ache | |
| <input type="checkbox"/> Ear pain | <input type="checkbox"/> Sinus pain/pressure | |
| <input type="checkbox"/> Runny / stuffy nose | <input type="checkbox"/> Wheezing | |
| <input type="checkbox"/> Stomach pain | <input type="checkbox"/> Loss of appetite | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Rash | |
| <input type="checkbox"/> Pain with urination | | |
| <input type="checkbox"/> Upper toothache | <input type="checkbox"/> Dark nasal mucous | |
| <input type="checkbox"/> Little/no improvement after trying a decongestant (e.g., Sudafed) | | |

Do you live with anyone in any of the following categories? (check all that apply)

- Less than 2 years old
- 65 years old or older
- Severe chronic illness (e.g., heart disease, asthma, kidney or liver disease, sickle cell disease, diabetes)
- Pregnant
- Immunosuppression (e.g., HIV / AIDS)
- Child on chronic aspirin therapy

What medicines, if any, have you taken for your symptoms so far?

Have you been in close contact with anyone with similar symptoms recently? (circle) NO YES

Have you been in close contact with anyone with the H1N1 (swine) flu? (circle) NO YES

Have you received the seasonal (regular) flu vaccine this year? (circle) YES NO

Have you received the H1N1 (swine) flu vaccine this year? (circle) YES NO

Do you smoke or dip? (circle) NO YES

If yes, how much, and how long? _____

Do you want to quit? (circle) NO YES
 (Note: I recommend you not use tobacco. I can help you quit.)

Is this your first visit to GMA in the past 3 years? (circle) NO YES

Do you need a letter for school / work? (circle) NO YES

Females, please continue:

Is there a possibility you might be pregnant? (circle) NO YES

Are you breast feeding? (circle) NO YES

Last Menstrual Period: _____

THANK YOU!