To help us get the most out of today’s visit, please answer the following questions:

1. What is your main purpose in coming to our office today? (If you have a new complaint, indicate how long it has been present, - what it feels like, what makes it better or worse, and what you are concerned the problem might be.)

2. Have you developed any new drug allergies?  ☐ Yes (list below) ☐ No

3. How much tobacco do you smoke or chew per day? ________________________________________________

   Would you like more information on a tobacco-cessation class?  ☐ Yes ☐ No


   List all medications you are taking (use backside if needed): ________________________________________________

5. Over the past 2 weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th></th>
<th>Not At All</th>
<th>Several Days</th>
<th>More than Half the days</th>
<th>Nearly Every</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>B. Feeling down, depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Sleep Disturbance Symptoms

1. Have you been told you snore loudly? Y N
2. Do you stop breathing at night or wake up feeling short of breath (choking/gasping)? Y N
3. Do you fall asleep during the day when sitting still? Y N

Allergy Symptoms

1. Do you experience any of the following: (circle all that apply)

   Hayfever  Runny Nose  Nasal Congestion  Sneezing  Watery Eyes  Itchy Throat  Itchy Skin  Cough

   Refer to Allergy Lab

Female Patients

1. Do you lose urine while coughing, sneezing, laughing, lifting, jumping, or running? Y N
2. Do you experience heavy bleeding during your menstrual cycle lasting more than 7 days? Y N
3. Do you experience pelvic pain during your menstrual cycle? Y N
4. Do you experience menopausal symptoms, such as hot flashes and/or irritability? Y N

Refer to Urodynamics

Refer to GYN