Patient Questionnaire

Name_____ DOB_____ Date_____

Age_____ Sex: M F Marital Status: S M D W Occupation_____

Spouse's Name_____ Spouse's Occupation_____

Children's Names and Ages_____

_____

List Current Medical Problems_____

Present or Past Medical Problems_____

Surgeries and Dates_____

Immunizations (Give date of most recent immunization) Tetanus_____ Influenza_____

Pneumonia_____ Hepatitis A_____ Hepatitis B_____ Hepatitis AB_____

Zostavax_____ Other_____

Current Medications (If more space is needed, please use second page)

Medication	Dosage	How often taken

Name:_____ DOB_____

Allergies to medications and other substances (If more space is needed, please use second page)

Medication	Type of reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History (List relative with any of the following problems)

Heart disease_____

High blood pressure_____

Diabetes_____

Cancer_____

Other inherited disease_____

Emotional problems_____

Health Habits (Circle the most appropriate)

Tobacco use	Never	Rarely	Frequently	How long:_____
Past Smoker	Year quit:_____			
Alcohol	Never	Socially	Frequently	
Street Drugs	Never	Occasionally	In the Past	
Exercise	Never	Occasionally	Regularly	

Doctors or Specialists you are seeing or have seen in the past

_____

_____

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_____

Name_____ DOB_____

Have you had the following problems? (Include both recent past and present)

GENERAL

Poor appetite	Yes	No
Anemia or low blood count	Yes	No
Recent weight change	Yes	No
Unusual fatigue or weakness	Yes	No
Thyroid problems	Yes	No
Diabetes/high blood sugar	Yes	No
Frequent fever or chills	Yes	No
Frequent or unusual lymph glands or lumps	Yes	No
Sleep difficulties	Yes	No

HEAD

Frequent, severe or unusual headaches	Yes	No
Recent changes in vision	Yes	No
Glaucoma	Yes	No
Frequent, unusual dizziness	Yes	No
Hearing difficulties	Yes	No
Ringing in ears	Yes	No
Frequent nosebleeds	Yes	No
Difficulty swallowing	Yes	No
Persistent hoarseness	Yes	No

LUNGS

Worsening shortness of breath	Yes	No
Asthma or emphysema	Yes	No
Frequent cough	Yes	No
Coughing up blood/phlegm	Yes	No
Tuberculosis	Yes	No
Recurrent pneumonia or bronchitis	Yes	No

HEART

Heart murmur	Yes	No
History of heart failure	Yes	No
Waking up at night because of shortness of breath	Yes	No
High blood pressure	Yes	No
Rheumatic fever	Yes	No
Chest pain or pressure	Yes	No
Heart attack	Yes	No
Irregular heartbeat	Yes	No
Swelling in legs	Yes	No
Severe calf pain when walking	Yes	No
Racing heart	Yes	No

DIGESTIVE TRACT

Indigestion or heartburn	Yes	No
Ulcers	Yes	No
Frequent unusual abdominal pain	Yes	No
Vomiting blood	Yes	No
Hepatitis or liver problems	Yes	No
Gallbladder problems	Yes	No

DIGESTIVE TRACT (Continued)

Frequent diarrhea	Yes	No
Hemorrhoids	Yes	No
Rectal bleeding	Yes	No
Black, tarry bowel movements	Yes	No
Recent change in bowel habits	Yes	No

URINARY

Bladder or kidney infection	Yes	No
Kidney stones	Yes	No
Burning with urination	Yes	No
Slow urine flow	Yes	No
Difficulty starting urine	Yes	No
Difficult control of urine	Yes	No
Blood in urine	Yes	No
Venereal disease	Yes	No

GENITALIA

Men: Prostate problem	Yes	No
Discharge from penis	Yes	No
Lump in testicles	Yes	No
Women: Breast lump	Yes	No
Discharge from nipple	Yes	No
Irregular periods	Yes	No
Abnormal vaginal bleeding or spotting (not with periods)	Yes	No
Abnormal PAP test	Yes	No

Age of onset of periods_____
Cycle_____ days (start to start)
Birth control method_____
Number of pregnancies_____
Number of children_____

BONES/JOINTS

Painful/swollen joints	Yes	No
Persistent back or neck pain	Yes	No

PSYCHOLOGIC

Have you recently thought about suicide?	Yes	No
Suicide attempt	Yes	No
Frequent anxiety	Yes	No
Frequent depression	Yes	No
Job or family difficulty	Yes	No
Loss of interest in usually stimulating activities	Yes	No

NEUROLOGIC

Seizures or epilepsy	Yes	No
Previous stroke	Yes	No
Numbness of face, arm or leg	Yes	No
Weakness of face, arm or leg	Yes	No
Fainting or loss of consciousness	Yes	No
Difficulty with speech	Yes	No