Patient Questionnaire

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Patient Name:_____ DOB:_____ Date:_____

What is your medical problem and how long have you had it? _____

_____

What is your main symptom?_____

_____

Check illness or conditions you have had:

☐ Cancer ☐ Asthma ☐ Hepatitis ☐ Diabetes ☐ Glaucoma ☐ Heart Trouble ☐ GERD ☐ Vein Trouble

☐ Emphysema ☐ Nervous Disorder ☐ High Blood Pressure ☐ Bleeding Tendencies ☐ Thyroid Problem

☐ Pneumonia ☐ Kidney Disease ☐ High Cholesterol ☐ Arthritis

Previous Operations with Dates: ☐ Tonsillectomy Year_____ ☐ Appendectomy Year_____

☐ Other Operations with Year _____

Have you ever had a Blood Transfusion? ☐ No ☐ Yes When_____

When was your last colonoscopy? Year_____

When was your last TB skin test or Chest X-ray? _____

Please list any other Illnesses NOT requiring operation for which you were hospitalized:_____

_____

Have you had serious injuries, broken bones, Etc.? ☐ No ☐ Yes List:_____

Dressed Weight:_____ How long have you been at this weight?_____

Women only:

Number of Pregnancies?:____Number of Miscarriages?:____ Onset Date of Last Menstrual Period?:_____

Periods are: ☐Regular ☐Irregular Have you gone through Menopause? ☐ Yes ☐ No

Any complications in pregnancies? Please list: _____

Last Mammogram Date:_____ _ ☐ Normal ☐ Abnormal

Last PAP Smear Date:_____ ☐ Normal ☐ Abnormal

Men Only: When was your last PSA (prostate blood test)?: _____

Please list all medications you are currently taking and why?

Medications/Dosage	**Reason for Medication**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you take? Mark YES OR NO Aspirin_____ Vitamins_____ Laxatives _____ Steroids_____

Please list any medication allergies:

Medication	**Reaction/symptom**
_____	_____
_____	_____

Are you allergic to Iodine? ☐ YES ☐ NO

Family History:

Has anyone of your blood relatives had the following problems? Please give the family member and other relevant information below:

Cancer:

Who	What Kind	Age Found	Still Living	Did they die of this?
_____	_____	____	Yes or No	Yes or No
_____	_____	____	Yes or No	Yes or No
_____	_____	____	Yes or No	Yes or No

Heart Attack or Stroke:

Who	Heart or Stroke	Age of Problem	Still Living	Did they die of this?
_____	_____	____	Yes or No	Yes or No
_____	_____	____	Yes or No	Yes or No
_____	_____	____	Yes or No	Yes or No

Any other Problems or Diseases among your blood relatives?

Alcoholism	Yes ☐	No ☐	_____
Anemia	Yes ☐	No ☐	_____
Allergies	Yes ☐	No ☐	_____
Asthma	Yes ☐	No ☐	_____
Arthritis	Yes ☐	No ☐	_____
Depression	Yes ☐	No ☐	_____
Diabetes	Yes ☐	No ☐	_____
Glaucoma	Yes ☐	No ☐	_____
High Cholesterol	Yes ☐	No ☐	_____
Hypertension	Yes ☐	No ☐	_____
Kidney disease	Yes ☐	No ☐	_____
Migraine Headaches	Yes ☐	No ☐	_____
Obesity	Yes ☐	No ☐	_____
Osteoporosis	Yes ☐	No ☐	_____
Thyroid disease	Yes ☐	No ☐	_____
Tuberculosis	Yes ☐	No ☐	_____
Ulcer disease	Yes ☐	No ☐	_____
Other (Specify)	Yes ☐	No ☐	_____

Your Immunizations: Have you had?

Tetanus shots	☐	Year of last shot_____
Measles Mumps Rubella	☐	Year of last shot_____
Pneumovax	☐	Year of last shot_____
Polio shots within the last 2 years	☐	Year of last shot_____
Influenza	☐	Year of last shot_____

Childhood Illness: Circle below those you have had

Measles	Chicken Pox
German Measles	Whooping cough
Mumps	Scarlet Fever
Rheumatic Fever	Polio
Diptheria	None

Social History:

Occupation:_____Married:_____

Have you traveled outside the US? ☐ Yes Where? _____

Do you Smoke? ☐ Yes ☐ No How many packs per day?_____ How Long?_____ When did you quit?_____

Do you drink alcoholic beverages? ☐ Yes ☐ No How often?_____

Have you ever used or do you currently use illicit drugs? ☐ Yes ☐ No Please explain:_____

Caffeine intake? Type:_____ Amount:_____

Review of Systems:
Within the last year have you had any of the following:

SKIN:	YES	NO
Change in hair texture		
Change in skin texture		
Any skin rash		
Any new or change in moles		

HEAD, EAR, EYE, NOSE, THROAT:	YES	NO
Blurred vision		
Double vision		
Spots before eyes		
Infected eyes		
Pain behind eyes		
Any change in vision		
Do you wear glasses		
When were they last checked		
Earaches		
Discharge from ears		
Ringing in ears		
Decrease in hearing		
Recurrent nose bleeds		
Recurrent head colds		
Sinus trouble		
Hay fever		
Strange persistent odors		
Strange taste or loss in taste		
Persistent hoarseness		
Difficulty swallowing		
Enlarged glands		
Recurrent sore throats		
Recurrent sores in mouth		
Soreness or bleeding of gums on brushing		

CARDIOVASCULAR:	YES	NO
Chest pain		
Pain in arms		
Wake up at night short of breath		
Shortness of breath:		
One flight of stairs		
On laying down		
Purple lips or fingers		
Palpitations or fluttering of heart		
Swelling of hands, feet or ankles:		
At what time of day_____		
Leg cramps on walking or at night		
Enlarged veins in legs		
How many bed pillows do you use	_____	

GASTROINTESTINAL:	YES	NO
Recurrent stomach pain		
Belching or heartburn		
Relieved by food or medication		
Appetite Good Fair Poor		
Nausea or vomiting		
Vomited blood		
Avoid some foods		
What kinds_____		
Avoid spices		
Abdominal cramping		
Black bowel movement		
Any blood in bowel movement		
Rectal pain with bowel movement		
Bowel movements		
Frequency per day		
Change in size, shape or texture of BM		

Review of systems continued:

RESPIRATORY:	YES	NO
Shortness of breath		
Night sweats		
Chronic or frequent cough		
Chronic or frequent cough on laying down		
Wheezing		
Coughed up blood		

MUSCULO-SKELETAL:	YES	NO
Recurrent back pains		
Backaches		
Joint pains		
Swelling of any joints		
Redness or heat of any joint		

NEUROLOGIC:	YES	NO
Frequent or severe headaches		
Fainting spells		
Dizziness on change of position		
Unconscious spells		
Tingling or weakness of hands or feet		
Muscle spasms		
Loss or change of sensation in hands or feet		
Trembling of any extremity		

SIGMOIDOSCOPY OR COLONOSCOPY	YES	NO
Sigmoidoscopy		
Colonoscopy		
Do you know the findings?		

EKG:	YES	NO
Ever had an electrocardiogram?		
Abnormal		

ECHO:	YES	NO
Ever had an echocardiogram?		
Abnormal		

STRESS TEST:	YES	NO
Ever had a treadmill stress test?		
Abnormal		

GENITOURINARY:	YES	NO
Lose urine on coughing or sneezing		
Discharge from penis		
Pain in urinating		
Difficulty in starting urination		
Do you get up at night to urinate		
How many times?_____		
Any blood in urine		
Full feeling of bladder but only small amount of urination		

ENDOCRINE:	YES	NO
Goiter		
Hotflashes		
Tiredness without apparent reason		
Brittleness of nails		
Dryness of skin		
Inability to stand heat		
Inability to stand cold		

HEMATOLOGIC:	YES	NO
Easy bruising		
Bleeding problems		