Patient Questionnaire

Name:_____ **DOB:**_____ **Date:**_____

Allergies:_____

Medications/Supplements:_____

_____

_____

Past Medical History

*Please **Circle** those conditions you've had in the past or have currently:*

High blood pressure	Stroke	Hepatitis
Diabetes	Gallstones	Yellow Jaundice
Peptic Ulcers	Kidney Stones	Abdominal Bleeding
Heart Attack	Thyroid Problem	Diverticulosis
Asthma	Emphysema/COPD	Seasonal Allergies
Migraines	Anxiety	Depression
Heart Murmer	Broken Bones	Head Injury
Arthritis	Blood Clots	Cancer
Seizures	Physical/Sexual Abuse	
Other:		

Past Surgical History

Please list all surgeries you've had, along with the year of the surgery, if known.

_____

_____

_____

Have you ever had a blood transfusion? **Y N** *If yes, what year?*_____

Have you ever been hospitalized for other reasons? **Y N** *If yes, why?* _____

_____

Family History

Please tell me who was affected (e.g. father, sister) and how old they were when diagnosed

Heart Disease/Heart Attack/Stent/Bypass:_____

_____

Stroke:_____

High Blood Pressure:_____

High Cholesterol:_____

Diabetes:_____

Breast/Ovarian Cancer:_____

Colon Cancer:_____

Prostate Cancer:_____

Other Cancer:_____

Osteoporosis/Broken Bones:_____

Thyroid Problems:_____

Depression/Anxiety/Substance Abuse:_____

Bleeding Problems/Blood Clots:_____

Other:_____

Health Habits

Describe your home life: (Married? Children? Pets? Hobbies?)_____

_____

_____

Do you exercise? **Y** **N** How many times per week?_____

What types of activities?_____

How many hours of sleep do you get at night?_____

Do you drink caffeine? **Y** **N** If yes, how many servings per day?_____

Do you use tobacco? **Y** **N** If yes, circle which kind(s) Cigarettes/Pipe/Cigar/Chewing Tobacco

If yes, how much per day?_____ How many years?_____

Have you previously used tobacco? **Y** **N** If yes, what year did you quit?_____

Do you drink alcohol? **Y** **N** If yes, how many drinks per week?_____

Have you ever had medical, psychological, or legal troubles from alcohol?_____

Do you use recreational drugs? **Y** **N** If yes, which one(s)_____

If no, have you had significant use in the past?_____

Do you have guns in the home? **Y** **N** If yes, are they locked/unloaded?_____

Do you consider yourself at average or increased risk for HIV?_____

Symptom Review

*Please **circle** the symptoms below which have troubled you within the **past three months:***

Chest pain/Tightness	Palpitations	Back/Neck Pain
Fainting Spells	Swollen Ankles	Muscle Pain/Weakness
Shortness of Breath	Cough/Congestion	Arthritis Pain
Wheezing	Phlegm	Joint Pain/Swelling
Coughing up Blood	Trouble Swallowing	Rash
Heartburn	Nausea/Vomiting	Changes in moles/warts
Abdominal Pain	Jaundice	Tremor/Shakiness
Diarrhea	Constipation	Paralysis
Bloody/Black Stools	Blood in Urine	Frequent Headache
Painful Urination	Frequent Urination	Change in Speech/Vision
Leakage of Urine	Sexual Dysfunction	Numbness/Tingling
Penile/Vaginal Discharge	Menstrual Problems	Memory Loss
Hot Flashes	Inexplicable Fatigue	Crying Spells
Fever or Chills	Lumps or Masses	Insomnia
Wear Glasses/Contacts	Visual Changes	Hallucinations
Anxiety	Depression	Suicidal Thoughts
Eye Pain	Itchy/Watery Eyes	Bloody Nose
Runny Nose/Congestion	Sore Throat	Hoarseness
Hearing Aids	Earache	Tinnitus (Ringing in Ears)
Ear Drainage	Asthma	Sinus Problems
Excessive Thirst/Urination	Weight Changes	Hair or Skin Changes
Heat or Cold Intolerance	Easy Bruising	Easy Bleeding of Gums
Enlarged Lymph Nodes	Anemia	Pain in Legs with Walking

Food Intolerances (please list)