Patient Questionnaire

Patient Name:_____ DOB:_____ Today's Date:_____
Referring Physician:_____ Family Physician:_____
Home Phone: _____ Cell Phone: _____

HISTORY OF PRESENT ILLNESS:

1. What is the problem that brings you here today?_____
2. For what length of time have you had this problem?_____
3. What signs or symptoms are you having?_____
4. Does anything make the problem better or worse?_____
5. Does the problem interfere with normal daily function? CIRCLE: YES NO
6. How long does the problem last? CIRCLE: seconds; minutes; hours; days; all the time

MEDICATIONS:

List the names (and dose if known) of the medication you take everyday (including non-prescription meds):

ALLERGIES (Please List):

Are you taking the following medications: CIRCLE: Coumadin Glucophage Plavix Aspirin

PAST PERSONAL & FAMILY HISTORY

Please write Y (yes) or N (no) under SELF if you had any of the listed conditions.
Please write Y (yes) or N (no) under FAM if a family has had any of the listed conditions.

Condition	SELF	FAM	Condition	SELF	FAM	Condition	SELF	FAM
Anemia			Heart Attack			Radiation Therapy		
Arthritis			Heart Problems			Seizures		
Asthma			HIV/AIDS			Shortness of Breath		
Bleeding Troubles			High Blood Pressure			Stomach Ulcers		
Cancer			Hoarseness			Stroke		
Cholesterol			Immune Disease			Thyroid Problems		
Diabetes			Kidney Disease			Trouble w/ Anesthesia		
Emphysema			Liver Disease			Tuberculosis		
Glaucoma			Lung Disease					

MEN: CIRCLE: Abnormal PSA Prostate Biopsy Sexual Dysfunction

Have any of the men in your family ever had prostate cancer? YES_____ NO_____
Is YES, Circle: Father Brother Grandfather Uncle Cousin

WOMEN: CIRCLE: Abnormal Periods Female Hormone Problem Uterus/Ovaries-problem

Could you be pregnant now? YES_____ NO_____ Are you on birth control now? YES_____ NO_____
Type of birth control: Pill_____ Other_____ Number of Pregnancies?_____ Number of Births_____

PAST SURGICAL HISTORY:
List all of the operations you ever had and dates:

SOCIAL HISTORY:

Tobacco: Have you ever used? NO____ QUIT_____ years ago YES_____ #of years_____ Packs per day_____
Alcohol: Do you use alcohol? NO_____ Occasional_____ Daily_____
Marital Status: M S D W SEP **Occupation:**_____

REVIEW OF SYSTEMS: (Please check yes or no to each area if you are having any of the conditions below.)

Constitutional Symptoms	**NO**	**YES**	**Skin**	**NO**	**YES**
Aches and pains			Acne		
Chills			Boils		
Easy Bruising			Changing Moles		
Fever			Persistent Itch		
Fatigue			Pigment Change		
Headaches			Skin Rash		
Weight Loss/Gain			**Musculoskeletal**		
Eyes			Back Pain		
Blind			Gout		
Blurred/Double Vision			Joint Pain		
Pain			Muscle Cramps		
Worsening Eyesight			Muscle Weakness		
Allergic/Immunologic			Neck Pain/Stiffness		
Animal Allergies			**Ear/Nose/Throat/Mouth**		
Environmental Allergies			Ear Infection		
Food Allergies			Sinus Problems		
Seasonal Allergies			Sore Throat		
Neurological			**Genitourinary**		
Disoriented			Kidney or Bladder Infection		
Dizzy Spells			Kidney or Bladder Stone		
Leg/Arm Weakness			Blood in Urine		
Memory Loss			Urinary Incontinence		
Numbness/Tingling			Slow Urination		
Endocrine			Painful Urination		
Excessive Thirst			Bladder Trouble		
Tired/Sluggish			Frequency		
Too Hot/Cold			Urgency		
Gastrointestinal			Bladder Cancer		
Abdominal Cramps			**Respiratory**		
Acid Reflux			Frequent Cough		
Bloody Stools			Pneumonia		
Constipation			Wheezing		
Diarrhea			**Hematologic/Lymphatic**		
Hemorrhoids			Swollen Glands		
Indigestion/Heartburn			Blood Clotting Problem		
Nausea/Vomiting			Sickle Cell		
Cardiovascular			**Psychological**		
Chest pain or Pressure			Anxiety		
Edema/Swelling			Depressed		
Irregular Heartbeat			Generally Satisfied with Life		
Mitral Valve Prolapse					
Palpitations					
Skipped Heartbeats					

Patient Signature:_____ **Date:**_____