

Patient Questionnaire

Name: _____ Date: ____ / ____ / ____ Age: ____ Chart #: _____

Have you ever been seen in this office? Y N If yes, by whom and when? _____

Referring Doctor: _____ Other Doctors Presently Seeing: _____

Chief Complaint: _____ Duration: _____ days weeks months years
(circle one)

Past/Present Illness(es), Please Check if Applicable:

Diabetes ___ HIV ___ Stroke ___ Blood Clot ___ Currently Pregnant ___ Hernia ___

Thyroid ___ High Blood Pressure ___ Hepatitis A B C ___ Asthma or Lung Disease ___ Arthritis ___

Elevated Cholesterol ___ Gallstones ___ Endometriosis ___ Kidney Disease ___ Cancer ___

Heart Disease ___ Gastrointestinal Disease ___ Other _____ Other _____

All Past Major/Minor Surgeries (list with approximate age):

Accidents (any injury of consequence with approximate age)

Personal History/Habits:

Occupation: _____ Allergies: None ___ Iodine ___ Tape ___ I.V. Contrast ___ Latex ___

Other Allergies: _____

Medication allergies: _____

Smoke: Y N (circle one) If so, # packs per day ___ Previously smoked: Y N (circle one)

Consume alcohol: Y N (circle one) Approximately # drinks: ___ per day week month (circle one)

Recreational drugs: Y N (circle one) Type: _____ daily weekly monthly (circle one)

Take aspirin: Y N (circle one) Herbal medication(s) / vitamin(s): Y N (circle one)

Family History:

Allergies ___ Bleeding ___ Tuberculosis ___ Diabetes ___ Heart Disease ___

Stroke ___ Amputations ___ High Blood Pressure ___ Other _____

Cancer(s) and type: _____

please continue on reverse side

List all medications, dose and frequency:

Name of Medicaton	Dose (ie. 25mg)	Frequency (times per day)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check if you have/had any of the following symptoms:

Yes	NO		Yes	No	
___	___	Swelling in neck	___	___	Abdominal/groin pain
___	___	Severe hearing loss	___	___	Heartburn
___	___	Severe headaches	___	___	Hemorrhoids
___	___	Prolonged hoarseness	___	___	Skin turns yellow
___	___	Persistent neck rigidity	___	___	Vomiting
___	___	Repeated nosebleeds	___	___	Spit up/vomit blood
___	___	Skipping heart beats	___	___	Difficulty swallowing
___	___	Heart murmur/defect(s)	___	___	Difficulty/pain urinating
___	___	Difficult breathing	___	___	Blood in urine
___	___	Sit up to breathe easily	___	___	Leakage of urine
___	___	Chest pain on effort	___	___	Frequent night urination
___	___	Chronic cough	___	___	Anxiety
___	___	Night sweats	___	___	Numbness/paralysis
___	___	Ankle swelling	___	___	Insomnia
___	___	Leg pain	___	___	Memory loss
___	___	Varicose Veins	___	___	Seizures
___	___	Pain after eating	___	___	Shaking
___	___	Loss of weight	___	___	Speech disturbance
___	___	Loss of appetite	___	___	Dizzy spells
___	___	Blood from rectum	___	___	Failing vision/glaucoma
___	___	Nausea	___	___	Excess Menstruation
___	___	Habitual constipation	___	___	Bled between/missed period(s)
___	___	Chronic diarrhea	___	___	Breast pain
___	___	Black tarry stools	___	___	Breast lump
___	___	Light colored stools	___	___	Abnormal mammogram

Patient Signature

Date