

**PLEASE COMPLETE THIS FORM IN PEN**

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**PATIENT QUESTIONNAIRE / HISTORY**

**NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_  
First Initial Last

**SEX** \_\_\_\_\_ **DOB** \_\_\_\_\_ **AGE** \_\_\_\_\_

**Height** \_\_\_\_\_ **Weight** \_\_\_\_\_

**MEDICAL HISTORY:** (Circle all that apply)

- |                |                           |                      |
|----------------|---------------------------|----------------------|
| Anemia         | Blood Transfusion         | Abnormal Bleeding    |
| Anxiety        | Enlarged Prostate         | Breast Cancer        |
| Arthritis      | Glaucoma                  | Cancer of the Uterus |
| Asthma         | Heart Murmur              | Colon Cancer         |
| Depression     | Heart Rhythm Problems     | Crohn's Disease      |
| Diverticulosis | High Blood Pressure       | Hypothyroid (low)    |
| Diabetes       | Heart Valve Damage        | Hyperthyroid (high)  |
| Emphysema      | High Cholesterol          | Other Cancer         |
| Gallstones     | Irritable (Spastic) Bowel | Prostate Cancer      |
| Heart Attack   | Kidney Stones             | Seizures             |
| Hepatitis      | Pancreatitis              | Stroke               |
| Mental Illness | Ulcerative Colitis        | Stomach Ulcer        |
| Migraines      | Sleep Apnea               |                      |

Other \_\_\_\_\_

**PREVIOUS OPERATIONS:** (Circle all procedures you have had and indicate the age you were when they were done)

- |               |       |                        |       |
|---------------|-------|------------------------|-------|
| Angioplasty   | _____ | Aorta Aneurysm Surgery | _____ |
| Appendix      | _____ | Carotid Artery Surgery | _____ |
| C-Section     | _____ | Colon Surgery          | _____ |
| Gallbladder   | _____ | Coronary Artery Bypass | _____ |
| Heart Valve   | _____ | Cystoscopy (Bladder)   | _____ |
| Hernia        | _____ | Hemorrhoidectomy       | _____ |
| Hip Surgery   | _____ | Knee Arthroscopy       | _____ |
| Hysterectomy  | _____ | Stomach for Ulcer      | _____ |
| Mastectomy    | _____ | Varicose Veins         | _____ |
| Pacemaker     | _____ | Vascular Surgery Legs  | _____ |
| Prostate      | _____ | Other                  | _____ |
| Surgery       | _____ |                        |       |
| Implantable   |       |                        |       |
| Defibrillator | _____ |                        |       |

**MEDICATIONS:** PLEASE INCLUDE DOSAGES (List all prescriptions, over the counter drugs, aspirin, Motrin, vitamins and herbal supplements.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Office use:** Reviewed By \_\_\_\_\_ BMI \_\_\_\_\_ Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

**ALLERGIES TO MEDICATIONS:** \_\_\_\_\_

**ALLERGIES TO FOODS:** \_\_\_\_\_

**LATEX ALLERGY ?** \_\_\_\_\_

**EGG ALLERGY ?** \_\_\_\_\_

**SOCIAL HISTORY: (Circle)**

Do you smoke?                      Yes              No              Amount? \_\_\_\_\_

Do you drink alcohol?              Yes              No              Frequency? \_\_\_\_\_

Do you take Aspirin daily?              Yes              No

Do you take illegal drugs?              Yes              No

Occupation \_\_\_\_\_

Hobbies/Interests \_\_\_\_\_

**FAMILY HISTORY: (Circle)**

Bleeding Disorder	Colon Polyps	Diabetes	Stroke
Colon Cancer	Crohn's Disease	Heart Disease	Ulcerative Colitis

**REVIEW OF SYSTEMS: (Circle any problems that apply to you)**

**Constitutional/General**

- 5 lbs or more weight loss in the past yr.
- Fever within the past month
- Chills or sweats
- Chronic fatigue
- Loss of appetite

**Eyes**

- Blurred or double vision
- Cataracts or glaucoma

**Ears, Nose, Mouth and Throat**

- Hearing loss
- Ringing in the ears
- Sore throat/hoarseness
- Sinus problems
- Nose bleeds

**Cardiovascular**

- Chest pain or pressure
- Rapid or irregular heart beat
- Abnormal swelling in legs or feet

**Respiratory**

- Persistent cough
- Coughing up sputum or blood
- Exposure to Tuberculosis (TB)
- Difficulty breathing
- Bronchitis

**Musculoskeletal**

- Pain/stiffness/swelling in joints
- Backaches
- Muscle weakness
- Osteoporosis

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**Gastrointestinal**

- Nausea or vomiting
- Vomiting of blood
- Heartburn
- Gas or bloating
- Difficulty swallowing solids
- Abdominal pain
  - Location \_\_\_\_\_
  - Related to \_\_\_\_\_
  - Relieved by \_\_\_\_\_
  - Frequency \_\_\_\_\_
- Constipation
- Diarrhea
- Blood in stool
- Dark tarry stools
- Jaundice
- Occult blood (hidden blood in stool)

**Genitourinary**

- Frequency of urination
- Leaking urine
- Difficulty starting urinary stream
- Burning/pain with urination
- Blood in urine
- Urinary tract infections
- Frequent night urination

**Skin**

- Skin rashes
- Allergic reactions

**Neurological**

- Frequent headaches/migraines
- Dizziness
- Problems with equilibrium
- Numbness or tingling
- Slurred speech
- Loss of consciousness

**Psychiatric**

- Anxiety
- Memory loss
- Depression

**Hematologic/Lymphatic**

- Enlarged glands (lymph nodes)
- Excessive bruising

Has any family member seen our physicians? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of family member \_\_\_\_\_

Office use: Reviewed By \_\_\_\_\_

Date \_\_\_\_\_