

PATIENT QUESTIONNAIRE

Name: _____ Date: _____

Age: _____ Weight: _____ Height: _____

Has a doctor in this office previously seen you? _____

Referring Doctor: _____

Main Problem / Reason for Visit: _____

PERSONAL MEDICAL HISTORY

Have you had any of the following?

	Yes	No
High Blood Pressure	_____	_____
Heart Attack	_____	_____
Stroke	_____	_____
Epilepsy	_____	_____
Migraine	_____	_____
Mental Illness	_____	_____
Memory Loss	_____	_____
Cancer	_____	_____
Diabetes	_____	_____
Arthritis	_____	_____
Rheumatic Fever	_____	_____
HIV	_____	_____
Pneumonia	_____	_____
Tuberculosis	_____	_____
Other Illness	_____	_____

Have you been hospitalized for any other reasons?

	Yes	No
Please list	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List names of medications you are now taking

Are you allergic to any medicine?

_____ Yes _____ No

(Please list) _____

List all operations you have had:

Are you (please circle one):

single	married	divorced	widowed	other
_____	_____	_____	_____	_____

Are you working? _____

Do you have children? _____

Do you smoke? _____

Do you drink alcohol? _____

Education Grade completed _____

Is there any family history of

	Yes	No
Stroke	_____	_____
Heart attack	_____	_____
Epilepsy	_____	_____
Memory Loss	_____	_____
Other Medical Illness	_____	_____

Please '✓' to indicate if you have any of the following. Use a '?' if you are not sure.

General

- _____ Increased Fatigue
- _____ Weight Loss
- _____ Fever

Skin

- _____ Rash
- _____ Skin Cancer

Head / Neck

- _____ Headaches
- _____ Head Injury
- _____ Neck Pain
- _____ Neck Injury
- _____ Blurred Vision
- _____ Double Vision
- _____ Hearing Loss
- _____ Ears Ringing
- _____ Vertigo or Dizziness
- _____ Nose Bleeds
- _____ Loss of Smell
- _____ Hoarseness
- _____ Difficulty Swallowing

Respiratory

- _____ Cough
- _____ Asthma
- _____ Shortness of Breath

Cardiac

- _____ Angina
- _____ Irregular Heartbeat
- _____ Heart Murmur
- _____ Heart Failure
- _____ Heart Attack

Renal / Urinary

- _____ Change in Bladder Habits
- _____ Blood in Urine

Gastrointestinal

- _____ Loss of Appetite
- _____ Nausea
- _____ Vomiting
- _____ Vomiting of Blood
- _____ Blood in Stool
- _____ Change in Bowel Habits
- _____ Hepatitis

Gynecological

- _____ Irregular Menstrual Cycles
- _____ Abnormal Vaginal Bleeding
- _____ Contraceptive Use
- _____ Pregnancy

Behavioral

- _____ Drug Abuse
- _____ Sexually Transmitted Disease
- _____ Unsafe Sexual Practices

Hematological

- _____ Transfusions
- _____ Anemia
- _____ Abnormal Bleeding

Endocrine / Metabolic

- _____ Diabetes
- _____ Thyroid Problems

Bones & Joints

- _____ Pain
- _____ Swelling
- _____ Injury

Emotional

- _____ Anxiety
- _____ Depression
- _____ Insomnia
- _____ Suicidal Thoughts
- _____ Previous Psychiatric Counseling