

PATIENT QUESTIONNAIRE

Name: _____ Age: _____ Date: _____
DOB: _____ Height: _____ Weight: _____
Referral Source or Physician Name: _____
Main reason for visit: _____

PERSONAL MEDICAL HISTORY
Have you had any of the following?

	<u>YES</u>	<u>NO</u>
Cancer		
Cholesterol Problems		
Depression		
Diabetes		
Heart Attack		
High Blood Pressure		
HIV		
Falls		
Memory Loss		
Meningitis		
Migraines		
Neuropathy		
Seizure		
Stroke		

CURRENT MEDICATIONS

Name	Dose	Frequency

Allergies: _____

Marital Status: S/M/D/W/other _____
Occupation: _____
Children: Y/N Ages: _____
Tobacco: Y/N
Alcohol: Y/N

Past Surgeries and Dates:

Do you have a Living Will? Y/N
Advanced Care Plan? Y/N
Power of Attorney? Y/N

Family History or Adopted _____
Cancer
Heart Disease
Memory Loss
Muscular Disorder
Neurologic Disorder

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
- _____ Tuberculosis
- _____ Pneumonia

CARDIAC

- _____ Angina
- _____ Irregular Heartbeat
- _____ Heart Murmur
- _____ Heart Failure
- _____ Rheumatic Fever

RENAL/URINARY

- _____ Kidney Devices
- _____ Change in bladder habits
- _____ Blood in the urine
- _____ Kidney Stones

GASTROINTESTINAL

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

GYNECOLOGICAL

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

BEHAVIORAL

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

HEMATOLOGICAL

- _____ Transfusions
- _____ Anemia
- _____ Abnormal Bleeding
- _____ Cancer or Malignancy

ENDOCRINE/METABOLIC

- _____ Diabetes
- _____ Thyroid Problems

BONE & JOINTS

- _____ Pain
- _____ Swelling
- _____ Injury

EMOTIONAL

- _____ Anxiety
- _____ Insomnia
- _____ Suicidal Thoughts
- _____ Previous psychiatric counseling