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Patient Medical Questionnaire-Confidential

(Please print clearly)

Name:______________________ Date of Birth:______________ Age:_______ Sex: M F

Phone: Home:______________________ Work:____________________ Cell:__________________

Years of school (circle one): 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Marital Status (circle one): Single Married Remarried Divorced Widowed Separate
How many years? _____ _____ _____ _____ _____ _____

Current Occupation:______________________ Location:____________________ Years:_________

Previous/other occupations, hobbies:____

Exposure to hazardous materials: Yes No Type:_______________________________________

Last date worked:____________________________ Are you disabled from work? Yes No

Reason:____

Spouse's Name: ________________________ Spouse's current occupation:__________________

Spouse's previous occupations, hobbies:____

Please list any other health care providers you are currently seeing:

____Date last seen:_______________

____Date last seen:_______________

____Date last seen:_______________

____Date last seen:_______________

What is the reason that brings you to our office: ☐ CARE visit ☐ Establishing care ☐ Problem(s)

Describe the problem(s) you are here for:____

How long have you had the problem(s)?:____

PAST MAJOR MEDICAL HSITORY:

Year	Procedure or Problem	Place of Hospitalization

PATIENTS MEDICAL HISTORY: Have you ever had or are you being treated for. . .

- ☐ Asthma, emphysema, or COPD
- ☐ Pneumonia
- ☐ Heart attack or chest pain
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Phlebitis or blood clots
- ☐ Stroke
- ☐ Migraine or sever head pain
- ☐ Nervous or psychiatric condition: ______________________
- ☐ Alcoholism or drug addiction

- ☐ Hepatitis
- ☐ Ulcer
- ☐ Colon Polyps
- ☐ Kidney disease or stones
- ☐ Bladder or kidney infection
- ☐ Urinary retention or incontinence
- ☐ Diabetes
- ☐ High cholesterol or triglycerides
- ☐ Thyroid condition
- ☐ Cancer: site________________
  - ☐ *Surgery* ☐ *Radiation* ☐ *Chemotherapy*

- ☐ Sexually transmitted disease(s): ______________________
- ☐ AIDS or HIV testing
- ☐ Blood transfusion
- ☐ Herpes or shingles
- ☐Polio
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Blood transfusion
- ☐ Other:________________ ______________________

Family History: List all immediate family members, including your family-of-origin. If family member is deceased, please list age at and cause of death.

	Living?	Age	Known Medical Conditions or Cause of Death
Spouse:			
Children:			
Mother:			
Father:			
Sister(s):			
Brother(s):			

Is there a history of any of the following in a blood relative (parents, grandparents, siblings, aunts, uncles, etc.)?

Alcohol/drug addiction	Diabetes	Kidney disease	Stroke
Aneurysm	Epilepsy	Kidney failure	Thyroid disease
Arthritis	Glaucoma	Kidney stones	Tuberculosis
Asthma/emphysema	Heart attacks/angioplasty	Liver problems	Other major conditions
Breast cancer	Heart Surgery	Migraine headaches	*(list)*
Colon cancer	High blood pressure	Nervous breakdown	________________________
Other cancer	High cholesterol/triglyceride	Psychiatric condition(s)	________________________

MEDICATIONS: List all medications you've been taking recently. Include over-the-counter medicines and supplements.

****PLEASE BRING ALL MEDICINE****

Name Dose(mgs & times per day) Date Started Date Stopped

1.____

2.____

3.____

4.____

Name Dose(mgs & times per day) Date Started Date Stopped

5.____

6.____

7.____

8.____

Have you used "recreational" drugs? YES NO What/When?____

ALLERGIES or reactions to medicine or other substances. List all medications and substances.

Name of Medication/Substance Type of Reactions

1.____

2.____

3.____

Name of Mediation/Substance Type of Reactions

4.____

5.____

6.____

IMMUNIZATIONS/VACCINES and Dates

Pneumonia (Pneumovax)____________________

Measles______________________________

Tetanus______________________________

Hepatitis______________________________

H1N1 Flu______________________________

Seasonal Flu______________________________

Herpes Zoster (Shingles)__________________________

Other______________________________

PREVIOUS STUDIES/APPROXIMATE DATE: Please bring copies of recent test and x-ray results, if available.

☐ Chest X-ray____________________

Kidney/IVP____________________

Stomach/UGI____________________

Ultrasound of____________________

Stress test____________________

EKG____________________

Pulmonary Function______________

Cystoscopy____________________

Cat Scan____________________

PAP____________________

PSA____________________

Colon/Barium Enema______________

Gall Bladder____________________

Mammogram____________________

Prostate Exam____________________

Other____________________

Bronchoscopy____________________

Echocardiogram______________

MRI____________________

Proctoscopy____________________

Gastroscopy____________________

Colonoscopy____________________

Biopsy of____________________

PERSONAL HABITS AND LIFESTYLE

Tobacco: Have you ever used tobacco products? ☐ Yes ☐ No

Type:________________ Amount per day:____________ Years used:_______ If you've quit, when?______

Type:________________ Amount per day:____________ Years used:_______ If you've quit, when?______

If currently using, have you tried to stop? ☐ Yes ☐ No Do you wish to stop? ☐ Yes ☐ No

Alcohol: Amount consumed (including beer, wine and liquor):_________drinks per day, ________ times per week

Have you ever felt you should cut down on your drinking? ☐ Yes ☐ No
Have people annoyed you by criticizing your drinking? ☐Yes ☐ No
Have you ever felt bad or guilty about your drinking? ☐ Yes ☐ No
Have you ever had a drink in the morning to steady your nerves or get rid of a hangover? ☐ Yes ☐ No
Have you had a problem with your drinking? ☐ Yes ☐ No

Coffee, Tea and Cola Beverages: Amount per day?____
Travel: Where and when in the last 2 years?____
Diet: Any special diets or changes in eating habits?____
Exercise: Any exercise? ☐Walking ☐Sports______________________________ ☐Other________________
Sleep: Average # hrs sleep/night___ Do you have a regular bedtime/wake time? ___/___ Do you nap?☐Yes ☐No
Safety: Do you wear a seat belt? ☐ Yes ☐ No
If you participate in high risk activities such as flying, parasailing, etc., please list___________________
Advanced Directive:
Do you have a Living Will? ☐Yes ☐No Date:__________________________
Do you have a Power of Attorney or Health Care Power of Attorney? ☐Yes ☐No Date:______________
If you answered "yes" to either of these questions, please bring copies for your patient record.

CURENT/RECENT MEDICAL CONDITIONS AND REVIEW OF SYSTEMS		***Please do not write in this space***
Is the purpose of this examination to determine disability?	☐Yes ☐No	
Have you had an injury for which there is now a Lawsuit pending?	☐Yes ☐No	
Do you have any of the following:		
Recent weight gain? (amount)____________________	☐Yes ☐No	
Recent weight loss? (amount)____________________	☐Yes ☐No	
Fever or soaking sweats at night?	☐Yes ☐No	
Fatigue?	☐Yes ☐No	
Weakness, numbness, tingling or night cramps of arms or legs?	☐Yes ☐No	
New, frequent or severe headaches?	☐Yes ☐No	
Falls, imbalance or difficulty walking?	☐Yes ☐No	
Loss of consciousness, fainting or convulsions?	☐Yes ☐No	
Loss of memory or confusion?	☐Yes ☐No	
Problem with vision or eyes?	☐Yes ☐No	
Date/Provider of last eye exam?_______________/____________________		
Do you wear glasses or contact lenses?	☐Yes ☐No	
Head or ear noises?	☐Yes ☐No	
Change in hearing?	☐Yes ☐No	
Do you use a hearing aid?	☐Yes ☐No	
Change in speech or voice?	☐Yes ☐No	
Dizziness?(☐ Spinning ☐ Lightheadedness)	☐Yes ☐No	
Frequent or sever nosebleeds?	☐Yes ☐No	
Trouble chewing or swallowing?	☐Yes ☐No	
Sore tongue or mouth or dental problems?	☐Yes ☐No	

			Please do not write in this space
Daily cough or cough with bloody phlegm?	Yes	No	
Shortness of breath after walking up two flights of stairs and hurrying?	Yes	No	
Shortness of breath when just sitting or reclining?	Yes	No	
Discomfort or pain in chest?	Yes	No	
Swelling of the ankles every day?	Yes	No	
Pain or tiredness in the legs while walking?	Yes	No	
High blood pressure? Years:_______________	Yes	No	
Recent blood pressure reading____________/______________			
Abdominal pain?	Yes	No	
Frequent heartburn or indigestion?	Yes	No	
Change in bowel habits?	Yes	No	
Black or bloody bowel movements?	Yes	No	
Difficulty urinating?	Yes	No	
Do you lose control of urine at times?	Yes	No	
Awaken at night more than once to urinate?	Yes	No	
Sexual problems or change in sex drive?	Yes	No	
Do you have any discharge	Yes	No	
Any changes in skin, moles, rash?	Yes	No	
Persistent painful, stiff or swollen joints?	Yes	No	
Back pain or discomfort?	Yes	No	
Do you enjoy your work?	Yes	No	
How many people in your household?	_________		
Any stress or frequent conflicts at home?	Yes	No	
Do you feel anxious or depressed much of the time?	Yes	No	
Have you seriously considered suicide?	Yes	No	
Difficulty in sleeping?	Yes	No	
WOMEN ONLY:			
Are you menstrual periods normal?	Yes	No	
Date of last menstrual period?	Yes	No	
Bleeding between periods or after menopause?	Yes	No	
Any “hot flashes”?	Yes	No	
Any pain or dryness with intercourse?	Yes	No	
Any breast discharge?	Yes	No	
Pregnancies__________ Deliveries__________			
Miscarriages__________ Abortions___________			
Approximate date of last PAP smear:_____________________			
Have you used hormones?	Yes	No	

Have we left anything out that you are concerned about or feel is important about your health? ________________

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________________________________ ______________ ___________________________________

Patient Signature *Date* *Reviewed by Physician*