Patient Medical Questionnaire

Please fill out this information sheet (both sides) to help your doctor

Name:________________________Today's Date:_________Your Doctor:__________
Age:_____Birthdate:__________Occupation:________________________________
Sex:__-Male __-Female Single:__ Married:__ Separated:__ Divorced:__ Widowed:__

MAIN COMPLAINTS: For How Long?

a) ____ ________________
b) ____ ________________
c) ____ ________________

SURGERY or HOSPITALIZATION: Kind of operation or illness? When?

a) ____ ________________
b) ____ ________________
c) ____ ________________

PAST ILLNESSES: Circle any illnesses you have had and write down when:

	When?		When?		When?
Scarlet Fever	________	Unconsciousness	________	Tuberculosis	________
Pneumonia	________	High Blood Pressure	________	Diabetes	________
Heart Attack	________	Rheumatic Fever	________	Chicken Pox	________
Allery	________	Kidney Disease	________	Cancer	________
Anemia	________	Liver Disease	________	Asthma	________

FAMILY HISTORY:	Age	If living - list any disease	Age	If deceased - list cause
Father	____	________________	____	________________
Mother	____	________________	____	________________
Brother (B) ( )	____	________________	____	________________
Sister (sis) ( )	____	________________	____	________________
( )	____	________________	____	________________
( )	____	________________	____	________________
Son (S) ( )	____	________________	____	________________
Daughter (D) ( )	____	________________	____	________________
( )	____	________________	____	________________

Have any of your blood relatives (including grandparents, blood-related aunts or uncles) had the following diseases? Circle if YES

Heart Disease	Stroke	Kidney Disease	Psychiatric Disorder
Tuberculosis	Cancer	Emphysema	Thyroid Disease
Congenital Disease	Alzheimer's	Diabetes	Allergy
Osteoporosis	High Blood Pressure		

SOCIAL HISTORY: Tobacco: Yes( ) No( ) How much per day?____________________
Alcohol: Yes( ) No( ) How much per day__/week__/month__/year___
Substance Abuse/Addiction:____
Caffeine Consumption: Yes( ) No( ). Regular Exercise: Yes( ) How often?________
Servings(_____) fruits & vegetables per day.
Do you always wear your seat belt? Yes( ) No( )
Sexually active? Yes( ) No( ) Method of family planning?____________________

Please list the MEDICATIONS you are currently taking:

1) ______________________________ 4) ______________________________
2) ______________________________ 5) ______________________________
3) ______________________________ 6) ______________________________

ALLERGIES TO MEDICATIONS? ( )No ( )Yes If YES, list below and describe reaction

1) ____________________ 4) ____________________
2) ____________________ 5) ____________________
3) ____________________ 6) ____________________

Systems Review (Check is YES)

METABOLIC

Weight Change____________( )
Warmer/Colder Than Others___( )
Increased Sweating__________( )
Goiter____________________( )
Increased Thirst____________( )
Increased Urination_________( )
Skin, Hair, Nail Change_____( )

RESPIRATORY

Short of Breath_____________( )
Wheezing__________________( )
Raise Phlegm_______________( )
Cough Up Blood_____________( )

HEAD/EYES/EARS/NOSE/THROAT

Headache__________________( )
Hearing Problem____________( )
Eye Problem________________( )
Ear Pain__________________( )
Dizziness_________________( )
Nasal Drainage_____________( )
Sore Mouth or Throat________( )

ALLERGIC/IMMUNOLOGIC

Hay Fever_________________( )
Asthma____________________( )
Rashes/Hives_______________( )
Allergies_________________( )

CARDIOVASCULAR

Chest Pain________________( )
Fast Heartbeat_____________( )
Irregular Heartbeat_________( )
Ankle Swelling_____________( )
High Blood Pressure_________( )
Calf Pain Walking___________( )

BLOOD/LYMPHATIC & CONSTITUTIONAL

Bleeding/Bruising___________( )
Anemia____________________( )
Enlarged Glands____________( )
Fever_____________________( )

URINARY

Blood in Urine_____________( )
Urinary Frequency__________( )
Pain With Urinating_________( )
Burning Urinating__________( )
Empty Bladder at Nighttime__( )
Bladder Leakage____________( )
Urgency___________________( )

NON-MEDICATION ALLERGIES?

If yes please list:

____
____
____
____

GASTROINTESTINAL

Heartburn_________________( )
Nausea/Vomiting____________( )
Trouble Swallowing_________( )
Abdominal Pain_____________( )
Blood in Stools____________( )
Black Stools_______________( )
Jaundice__________________( )
Change in Bowel Habits_( )
Constipation_______________( )
Diarrhea__________________( )
Belching/Gas_______________( )
Hemorrhoids________________( )

MUSCULOSKELETAL NEURO/PSYCHIATRIC

Back Pain_________________( )
Joint Pain________________( )
Stiff Neck________________( )
Muscle Weakness____________( )
Paralysis_________________( )
Tremor/Shakes______________( )
Numbness/Tingling__________( )
Convulsions_______________( )
Fainting__________________( )
Depression/Anxiety_________( )
Stress____________________( )
Sleeping Poorly____________( )

FEMALE PATIENTS:
Spot or Menstruate: _____Yes _____No
(Every_____ days, for _____ days each period)
Age of onset_____ Menopause_____
Last Period:_________ Last Pap Smear:___________
Breast Changes:____________________
Number of pregnancies, deliveries, complications,
Children & ages____________________
____
____
Calcium Intake:____________________
Do you do self breast exam? _____Yes _____No

VACCINES:

Tetanus	No_____	Yes (When?) _____
Pneumonia	No_____	Yes (When?) _____
Hepatitis B	No_____	Yes (When?) _____
Flu	No_____	Yes (When?) _____
MMR	No_____	Yes (When?) _____

MALE PATIENTS:
Impotence:____________________
Changes in Urinary Stream:____________________
Testicular Exam?____________________
Scrotal Lumps?____________________