PATIENT QUESTIONNAIRE & EXAM

DATE

PAGE #   CHART #

NAME | DATE OF BIRTH | AGE

OCCUPATION / EMPLOYER | HIGHEST LEVEL OF EDUCATION

REASON FOR VISIT

HOSPITALIZATIONS — *IF YOU HAVE BEEN IN A HOSPITAL OVERNIGHT - STATE THE YEAR - ILLNESS / OPERATION (DO NOT INCLUDE NORMAL PREGNANCIES. PLEASE START WITH THE MOST RECENT EVENT)*

YEAR	ILLNESS / OPERATION	YEAR	ILLNESS / OPERATION

PAST MEDICAL & FAMILY HISTORY — *PLEASE CHECK IF YOU (SELF) OR ANY BLOOD RELATIVE HAD ANY OF THE FOLLOWING CONDITIONS -*

	SELF	RELATION		SELF	RELATION
1) RECENT WEIGHT LOSS			17) LIVER DISEASE / HEPATITIS		
2) MIGRAINE HEADACHES			18) KIDNEY / BLADDER PROB.		
3) EPILEPSY / CONVULSIONS			19) NEUROLOGICAL PROB.		
4) EYE DISEASE *(OTHER THAN GLASSES)*			20) MEMORY PROBLEMS		
5) HEARING DISORDER			21) CONFUSION		
6) RECURRENT - NOSE BLEEDS			22) ARTHRITIS		
SINUS / THROAT INFECT(S)			23) OSTEOPOROSIS		
7) ANGINA - CHEST PAIN			24) CANCER - *TYPE:*		
8) HEART ATTACK			25) BLEEDING DISORDER		
9) HIGH BLOOD PRESSURE			26) BLOOD TRANSFUSION(S)		
10) STROKE			27) ANEMIA		
11) HIGH CHOLESTEROL			28) DIABETES		
12) HEART VALVE DISORDER			29) THYROID		
13) LUNG DISEASE			30) ALCOHOL OR DRUG ABUSE		
14) PEPTIC ULCER / HEARTBURN			31) MENTAL ILLNESS / DEPRESSION		
15) ASPIRIN - ARTHRITIS - PAIN PILLS			32) SLEEP PROB. / STRANGE LEG SENSATIONS		
16) BOWEL PROBLEMS			33) PSORIASIS / ECZEMA		
			34) EXCESSIVE SWEATING		

LIST ALL MEDICATIONS YOU TAKE

MEDICATION	DOSE	TIMES/ DAY

DO YOU NOW OR HAVE YOU EVER CONSUMED -

CIGARETTES Y N — PKG / DAY ____ # YRS ____

ALCOHOL Y N — DRINKS / WK ____

COFFEE / TEA Y N — CUPS / DAY ____

THE LAST TIME YOU HAD THE FOLLOWING TESTS, EXAMS OR VACCINES (YEAR)

CHOLESTEROL	____	Tetanus / Td	____
		Influenza (flu)	____
STOOL BLOOD	____	Pneumonia	____
		Hepatitis A	____
EYE	____	Hepatitis B	____
		Whooping C	____
DENTAL	____	Tdap (Tetanus, Diptheria, Whooping C)	____
TB	____	MMR (Red Measles, Mumps, Measles)	____
MALES PROSTATE - PSA	____	Meningitis	____
		Chicken pox	____
		HPV	____
		Shingles	____

DRUG ALLERGIES

FOR WOMEN ONLY

DATE OF LAST MENST PERIOD Y N

REGULAR CYCLE Y N ____

SPOTTING Y N   PAIN Y N

PRE-MENSTRUAL DYSPHORIC DISORDER Y N (MOOD SWINGS, IRRITABILITY, TENSION, BLOATING)

ARE YOU USING BIRTH CONTROL Y N

TYPE: ____

NUMBER OF PREGNANCIES ____

NUMBER OF BIRTHS ____

NUMBER OF ABORTIONS ____

NUMBER OF MISCARRIAGES ____

YEAR OF LAST -

- ____ PAP TEST ☐ NORMAL ☐ ABN
- ____ BREAST EXAM ☐ NORMAL ☐ ABN
- ____ MAMMOGRAM ☐ NORMAL ☐ ABN
- ____ BONE DENSITY TEST ☐ NORMAL ☐ ABN

DO YOU HAVE ANY OTHER PROBLEMS FOR WHICH YOU HAVE BEEN SEEING A DOCTOR ON A REGULAR BASIS? - *PLEASE LIST THEM*

ARE YOU HAVING ANY SYMPTOMS THAT YOU WOULD LIKE TO DISCUSS? - *PLEASE LIST THEM*

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