Patient Questionnaire

Date: _____

Name: _____ Date of birth: _____ Age: _____

Circle: Male / Female Circle: Married / Single / Divorced / Widowed Occupation: _____

Please list present medications:

Past Medical History:

Past Surgical History:

Procedure:	Year:

Allergies or sensitivities (please list reaction with allergies):

Allergy	Reaction	Allergy	Reaction

Personal history:

	Yes	No		
Exercise regularly			Number of times per week	
Caffeine			Number of cups per day	
Alcohol			Number of drinks per day/week	
Were you ever a problem drinker?				
Smoke			Number of packs per day	
If you ever smoked, when did you stop?				
Use other recreational drugs?			Now or in the past?	

Family History:

Father's age: _____ If deceased, list cause: _____

Mother's age: _____ If deceased, list cause: _____

Total # brothers: _____ Total # sisters: _____

Your children: Number living sons: _____ Number living daughters: _____

Number deceased children: _____ Cause: _____

Please check if any family members have any of the following history:

	Father	Mother	Sibling 1	Sibling 2	Sibling 3	Sibling 4	Child 1	Child 2	Child 3	Child 4
Heart disease										
High blood pressure										
Diabetes										
Stroke										
Cancer										
Other disease (list)										

Review of your body systems: Do you have now, or have you ever had, any of the following:

	Yes	No		Yes	No
Heart disease			Thyroid disease		
High blood pressure			Gallbladder disease		
Chest pain			Cancer (list location)		
Diabetes			Kidney stones		
Stroke			Blood in urine		
Asthma or emphysema			Swollen or painful joints		
Lung disease			Anemia		
Shortness of breath			Hepatitis, jaundice or liver disease		
Ulcers			Epilepsy		
Colitis			Nervous disorder		
Rectal bleeding			Depression		
Change in bowel habits			Back disorder		
Melanoma			Venereal disease		

Screenings & Immunizations:

	Year	Never		Year	Never
Pap smear (women)			Thyroid profile		
Mammogram			Flu vaccine		
Colonoscopy			Pneumonia vaccine		
Stool occult blood			Tetanus (DPT)		
EKG			Bone density		
Cholesterol			Stress test		
Fasting blood sugar			Carotid		

Women only:

Menstrual periods:

Onset date: _____ Regular or Irregular? _____ Date of last period: _____ Difficulty with periods?:_____

Pregnancies:

Number of children born alive: _____ Number of miscarriages: _____ Number of cesarean sections: _____

Number of premature babies: _____ Number of stillborns: _____

Describe any complications: _____