Patient History Questionnaire –Please bring to your appointment!

PATIENT INFORMATION

Last Name ___________________**First** _________________**MI**___ Sex M F Date:____________
Referring physician: ______________________________ Birth date: _______________ Age: _______
Any/All other doctors you see: ____

Race: ***(Circle One)*** White Am. Indian/AK Native Asian Black/African Am. Nat. Hawaiian Other Race Declined

Ethnicity: ***(Circle One)*** Hispanic or Latino Non-Hispanic or Latino Declined

HISTORY OF PRESENT ILLNESS

Reason for your visit: ____

♦ Location of Problem: ____________________________________Duration: _____________________
(Where on the body symptom occurs- Right or Left side if applicable) ***(How long have you had symptom? How long does it last?)***

♦ Severity: _______________________________________ Quality: ____________________________
(Severe, worse, slightly. Pain scale 1-10) ***(Character of symptom...burning, gnawing, stabbing)***

♦ Timing: ____ Context: ____________________________
(When symptoms occur) ***(Situation associated with symptom)***

♦ Modifying Factors: ____
(Things that make symptoms better or worse)

♦ Associated Signs/Symptoms: ____
(Other things that happen when this symptom occurs)

Medical History: *Please circle **Yes** or **No** if you have the following medical problems& explain below.*
High Blood Pressure . ..Yes No Respiratory Problems . ..Yes No >Type ____________________
Diabetes ……………. .Yes No Bleeding Problems. . . . .Yes No>Type_____________________
Stroke…………… . . . .Yes No Heart Trouble…………Yes No> Type_____________________
Cancer……………….. Yes No >> Type____
Other Problems____

What is your current weight? ________________ Height? ____feet ______inches

Current Medications/Dosage:

____
____
____

Drug Allergies: ____
____

Are you allergic to contrast dye? Yes No

Continue on reverse side of page

Past Hospitalizations/Surgeries/Injuries and Approximate Dates:

____
____
____
____

Family History: *Please list any medical problems in your relatives.*

Father: ____

Mother: ____

Siblings: ____

Others: ____________________ ____

Social History: Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Tobacco Use: ❑ Never ❑ Quit/ What age? _______ ❑ Smoker/ how much? ___________

Alcohol Use: ❑ Never ❑ Rarely ❑ Moderate ❑ Daily ❑ How much? _______________

Recreational Drug Use: ❑ Never ❑ Type and frequency ___________________________

Occupation: ________________________ Permanent Resident? Yes No

Review of Systems *Please circle* ***Yes*** *or* **No** *if you have any of the following problems.*

Constitutional

Good General Health	Yes	No
Recent weight change	Yes	No
Night sweats, fevers	Yes	No
Fatigue	Yes	No

Ears/Nose/Mouth/Throat

Hearing loss or ringing	Yes	No
Sinus problems	Yes	No
Nose bleeds	Yes	No
Sore throat/voice change	Yes	No

Eyes

Wear glasses/contacts	Yes	No
Blurred/double vision	Yes	No
Eye disease or injury	Yes	No
Glaucoma	Yes	No

Cardiovascular

Chest pain	Yes	No
Palpitations	Yes	No
Heart trouble	Yes	No
Swelling hands/feet	Yes	No

Respiratory

Shortness of breath	Yes	No
Cough	Yes	No
Wheezing/asthma	Yes	No
Coughing up blood	Yes	No

Gastrointestinal

Nausea/vomiting	Yes	No
Abdominal pain	Yes	No
Rectal bleeding	Yes	No
Bowel problems	Yes	No

Musculoskeletal

Muscle pain or cramp	Yes	No
Stiffness/swelling joints	Yes	No
Joint pain	Yes	No
Trouble walking	Yes	No

Neurological

Frequent headaches	Yes	No
Paralysis or tremors	Yes	No
Convulsions/seizures	Yes	No
Numbness/tingling	Yes	No

Integumentary (Skin/Breast)

Change in hair or nails	Yes	No
Rashes or itching	Yes	No
Breast lump	Yes	No
Breast pain/discharge	Yes	No

Endocrine

Excessive thirst/urination	Yes	No
Thyroid disease	Yes	No
Hormone problem	Yes	No

Hematologic / Lymphatic

Bruise easily	Yes	No
Slow to heal	Yes	No
Enlarged glands	Yes	No

Allergic/Immunologic

Food allergies	Yes	No
Aspirin allergies	Yes	No
Antibiotic allergies	Yes	No

Genitourinary -Male only

Blood in urine	Yes	No
Kidney stones	Yes	No
Sexual problems	Yes	No
Testicle pain	Yes	No

Genitourinary -Female only

Blood in urine	Yes	No
Kidney stones	Yes	No
Sexual problems	Yes	No
Menstrual problems	Yes	No

Psychiatric

Insomnia	Yes	No
Confusion/memory loss	Yes	No
Depression	Yes	No
Other ___________________		

Patient statement: To the best of my knowledge, the above information is accurate and complete.

Signed ______________________________________ **Date** ________________________________