Patient Questionnaire

Last Name: _____ First Name: _____ Date of Birth:_____

Male O Female O Occupation _____

Marital status: O Single O Partnered O Married O Separated O Divorced O Widowed

Previous doctor: _____ Date of last physical examination: _____

PERSONAL HEALTH HISTORY

Immunizations

Tetanus _____ Pneumonia/pneumovax _____ Hepatitis B _____

Influenza _____ Prevnar 13 _____ Shingles _____

Other: _____

MEDICAL HISTORY

O Alcohol/Drug problem	O Emphysema/COPD	O Liver Disease	O Blood clots
O Anemia	O Heart-Attack	O Osteoporosis	O Acid reflux
O Anxiety	O Coronary artery disease	O Prostate problem	O Neuropathy
O Arthritis	O Heart failure / CHF	O Depression	O Sleep apnea
O Asthma	O High Blood pressure	O Psychiatric problem	O Heart murmur
O Atrial fibrillation	O High cholesterol	O Seizure disorder	O Migraines
O Dementia	O Hypothyroidism (low)	O Stroke / CVA /TIA	O Hepatitis
O Diabetes	O Hyperthyroidism (high)	O Stomach ulcers	O Diverticulosis
O Cancer	O Kidney disease	O STD/sexual infection	O Colon Polyps
O Peripheral Arterial Disease		O Positive TB test	O Abnormal PAP test

O Other: _____

SURGERIES

O Appendectomy	O Tonsillectomy	O C-section	O Cardiac Bypass	O Hernia repair
O Hysterectomy	O Prostate surgery	O Gallbladder	O Vasectomy	O Heart stent / Angioplasty
O Tubal ligation	O Cataract surgery	O Breast surgery		

O Other: _____

SCREENING TESTS

Colonoscopy _____ Mammogram _____ PAP smear _____

Prostate test / PSA _____ Bone density test / DEXA _____ Eye exam _____

MEDICATIONS: List prescribed and over-the-counter medications

DRUG NAME:	DOSE & DIRECTIONS:	REASON:

ALLERGIES / REACTIONS TO MEDICATIONS

DRUG NAME:	REACTION / COMMENTS

LIST ANY FOOD OR ENVIRONMENTAL ALLERGIES AND REACTIONS

SOCIAL HISTORY	FAMILY HISTORY
Do you smoke currently? _____ How many packs per day? _____ For how many years? _____ Did you smoke previously? _____ If yes, how many packs per day? _____ For how many years? _____ When did you quit? _____ How many alcoholic drinks do you ingest per week on average? _____ Do you currently use any illicit / illegal drugs?_____	Do you have any grandparents, parents, siblings, or children with any of these problems? Diabetes _____ Heart disease _____ Cancer _____ High blood pressure _____ Stroke _____