PATIENT QUESTIONNAIRE

NAME:_____ **ALLERGIES**:_____
OCCUPATION:_____ **LANGUAGE(S) SPOKEN**:_____

REASON FOR YOUR VISIT:_____
1. Complete Physical:_____
2. Any Particular problem(s)? Please give details:_____

Have you ever had any of the following illnesses:

☐ Anemia/Blood disorder	☐ Itching or eczema	☐ Pancreatitis
☐ Severe Bleeding	☐ Migraine or headaches	☐ Intestinal disorder
☐ Cancer	☐ Nevritis	☐ Diverticulosis
☐ Glaucoma	☐ Bronchitis	☐ Food poisoning
☐ Cataract	☐ Pheumonia/pleursy	☐ Kidney Problem (stone)
☐ High or low blood pressure	☐ TB	☐ Prostate Problem
☐ Heart attack/Angina	☐ Arthritis/Rheumatism	☐ Urinary infection
☐ Varicose veins/Poor circulation	☐ Sciatica/Pinched nerve	☐ Epilepsy
☐ High cholesterol	☐ Back Problem	☐ Nervous Breakdown
☐ Diabetes/Hypoglycemia	☐ Bone Disease	☐ Anxiety/Panic attacks
☐ Gout	☐ Polio/Meningitis	☐ Frequent infections
☐ Thyroid disorder	☐ Stomach Problems (Ulcers)	☐ Veneral disease/PID
☐ Rheumatic Fever	☐ Liver disease	☐ HIV/AIDS
☐ Allergies/Sinus Problems	☐ Hiatal Hernia	☐ Herpes ☐ STD
☐ Asthma/Emphysema/Bronchitis	☐ Hepatitis/Jaundice	☐ Other illnesses_____

Have you ever had an accident? ☐ Yes ☐ No
☐ Fractures ☐ Back Injury ☐ Head Trauma ☐ with loss of consciousness?

Have you ever had surgery?

State what kind and approximate year:_____
_____

Were you ever hospitalized for other reasons? Please give details:_____
_____

Number of Pregnancies:_____ Abortions_____ Miscarriages_____ Live Births_____

Have you ever had?
☐ Chest X-ray ☐ Stomach or colon X-ray ☐ Spine ☐ Other X-rays, specify

Have you ever had:	**Vaccines**	**years of last**	**Vaccines**	**years of last**
☐ An electrocardiogram	Tetanos/TD	_____	Influenza(Flu)	_____
☐ An electroencephalogram	TDAP	_____	Pheumonia(P-vax)	_____
☐ Stools checked for occult blood	MMR	_____	Hepatitis	_____
	Mumps	_____	Hepatitis B	_____
☐ PPD Test	Measles	_____	Chickenpox	_____
☐ Blood transfusion(s)	Rubella	_____	Meningitis	_____
Date of last eye exam:_____	HIV (New Vaccine) _____			

OTHER SIDE

CURRENT MEDICATION INCLUDING THOSE OVER THE COUNTER:

CIVIL STATUS

Single/married/separated/divorced/widow?_____ Since when? _____

HABITS

Exercise regularly? ☐ YES ☐ NO Hours of sleep? _____

Smoking cigarettes: how many; per day: _____ per week_____ year quit_____

Alcohol: Now: little – moderate – a lot Before: little – moderate – a lot

Intake of coffee or tea: _____cups/day Work, how many hours a day? _____

FAMILY HISTORY

If any blood relative has suffered any of the following, please circle the number and indicate which relative

1. Heart disease
2. Cancer (which)
3. Stroke
4. COPD (Emphysema)
5. Diabetes
6. High Cholesterol
7. High blood pressure
8. Gout
9. Thyroid disorder
10. Alcoholism
11. Tuberculosis
12. Bleeds easily
13. Nervous breakdown
14. Epilepsy/Convulsions
15. Glaucoma
16. Migraine
17. Osteoporosis
18. Anemia
19. Asthma/hay fever
20. Hepatitis
21. Arthritis

SYMPTOMS

Your weight: Now? _____6 months ago _____your maximum _____when?_____

GENERAL

☐ Unusual fatigue or weakness
☐ Abnormal thirst
☐ Unusual loss of appetite-recent
☐ Unable to sleep
☐ Easily fatigued
☐ Fever/Night sweats
☐ Skin changes/bruise easily

ORL

☐ Vision problems
☐ Hearing problems/Earache
☐ Problem with nose,mouth& throat
☐ Pain or lump in the neck

HEART AND LUNGS

☐ Cough or sputum
☐ Shortness of breath
☐ Chest pain or pressure
☐ Palpitation/Heart murmur/ irregular pulse
☐ Swollen ankles
☐ Pain or lump in the breast(s)
☐ Date of last cholesterol test:_____
☐ Date of last breathing test: _____

EXTREMITIES

☐ Arthritis/Rheumatism
☐ Varicose veins/phlebitis
☐ Leg pain when walking
☐ Leg cramps
☐ Back pain

INTESTINAL

☐ Loss of appetite
☐ Trouble swallowing
☐ Abdominal pain
☐ Intolerance to fat(s)
☐ Change in bowel habits
☐ Constipation
☐ Diarrhea
☐ Belching or bloating/heartburn
☐ Black stool (like tar)
☐ Nausea and vomiting (with blood)
☐ Red blood in stools
☐ Hemorrhoids
☐ Hernia

MENSTRUATIONS

☐ Pain during periods
☐ Bleeding between your periods/after menopause
☐ When was your first period? Age _____
☐ When did your last period start? Date _____
☐ How many days does it last?
☐ How many tampons/pads used at every cycle?
☐ How many days between each period? _____
☐ How many pregnancies? ___Normal(s)___Abnormal(s)___Miscarriage(s)___ ☐ Abortion(s)
☐ Last Pap Smear? Date? _____ ☐Normal ☐ABN
☐ Last mammogram? Date? ___ ☐Normal ☐ABN
☐ Last Pap Smear? Date? _____ ☐
☐ Any vaginal discharge? _____ ☐ Any vaginal itching, burning or smell?____
☐ Pain/Bleeding during or after sex ☐Birth control method? _____
Birth Control Pill name _____
☐ Pain or lump in the breast(s)

KIDNEY, BLADDER AND GENETIALS

☐ Do you urinate at night? ____times?____
☐ Do you urinate often during the day?__time?__
☐ Difficulties in starting the urine stream?
☐ Blood in your urine?
☐ Any discharge from penis?
☐ Do you have lumps or testicular mass present?
☐ Any sexual problems?/Libido/Impotence/ Enjoyment
☐ Homosexuality

NEUROLOGY

☐ Frequent Headaches ☐ Fainting spells or loss of consciousness ☐ Seizures/Dizziness
☐ Temporary loss of strength, speech or vision ☐ Paralysis/Numbness ☐ Tremor/Hands shaking
☐ Emotional problems related to family, spouse, neighbor or co-worker?