University Internal Medicine and Diabetes Associates

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Patient Questionnaire

Date					
Name	D	ate of Birth			
Occupation	N	larital Status			
	your visit and the problems you				
Are you on a special diet? Yes	No If Yes, please explain:				
Are you allergic to any medication	ons? Yes No If Yes, Please	explain:			
Please list below your medicatio	ns and their dose:				
Please list below any surgery or	hospitalizations:				
D 1 2 W 10					
Do you smoke? Yes No If	Yes, how much and how long? _				
Do you drink alcohol? Yes No	If yes, how much and for ho	w long?			
Please check any of the followin	g illnesses that you have or may l	have had in the	past:		
Yes No	Yes		a mala mere	Yes	No
Mumps			arthritis		
Measles	pneumonia heart disease		hypertension		
Chickenpox Rheumatic fever	neart disease kidney disease		jaundice chorea		

Is there any family history of the following diseases? If yes, please list those family members who have the disease. Yes No Family member(s) affected: Yes No Family member(s) affected: Cancer Tuberculosis Tes No Yes No Weight change Indicate the unique state the discounting of the defence o	Scarlet fever			depression	Car	ncer	
Diabetes Cancer Tuberculosis T	Is there any family						
Heart Disease Hypertension Stroke High Cholesterol Please indicate Y or N of the following that you have and briefly explain: Yes No Yes No Yes No Yes No Yes No Weakness	Diahetes			,			
Hypertension Stroke					-		
Stroke High Cholesterol Please indicate Y or N of the following that you have and briefly explain: Yes No Weakness Fatigue Weight change increased thirst Insomnia burning with urination Fever blood in urine Chills kidney stones Night sweats dribbling with urination Itching urination at night Rash joint pain Abnormal bleeding Brusing Brusi					Tuberculosis _		
Please indicate Y or N of the following that you have and briefly explain: Yes No Yes No Weakness Fatigue difficulty swallowing Weight change indigestion Appetite change increased thirst Insomnia burning with urination Fever blood in urine Chills kidney stones Night sweats dribbling with urination Itching urination at night Rash joint pain Abnormal bleeding joint swelling Bruising muscle aches Headache goiter Fainting voice changes Seizures nervousness Dizziness depression Wision problems nightmares Muscle weakness memory loss Dry eyes Ringing in the ears Male: Decreased hearing penile discharge Sinus problem history of VD Hoarseness sexual problems Breast lump(s) Female: Cough age at start of periods: Chest pain last menstrual period: Shortness of breath # of deliveries Leg swelling vaginal bleeding Nausea abnormal bleeding Nausea Nausea bloom sexual problems							
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hemorrhoids