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Patient Questionnaire

Date_____

Name_____Date of Birth_____

Occupation_____ Marital Status_____
Please list below the purpose of your visit and the problems you would like to discuss today:

Are you on a special diet? **Yes**___ **No**___ If Yes, please explain:

Are you allergic to any medications? **Yes**___ **No**___ If Yes, Please explain:

Please list below your medications and their dose:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please list below any surgery or hospitalizations:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you smoke? **Yes**___ **No**___ If Yes, how much and how long? _____

Do you drink alcohol? **Yes**___ **No**___ If yes, how much and for how long? _____

Please **check** any of the following illnesses that **you** have or may have had in the past:

	Yes	**No**		**Yes**	**No**		**Yes**	**No**
Mumps	___	___	tuberculosis	___	___	arthritis	___	___
Measles	___	___	pneumonia	___	___	hypertension	___	___
Chickenpox	___	___	heart disease	___	___	jaundice	___	___
Rheumatic fever	___	___	kidney disease	___	___	chorea	___	___

Scarlet fever ___ ___ depression ___ ___ Cancer ___ ___

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:
Diabetes	___	___	_____	Cancer	___	___	_____
Heart Disease	___	___	_____	Tuberculosis	___	___	_____
Hypertension	___	___	_____				
Stroke	___	___	_____				
High Cholesterol	___	___	_____				

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		
Vision 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		
Dental problems					
Breast lump(s)			**Female:**		
Cough			age at start of periods:		
Chest pain			last menstrual period:		
Shortness of breath			# of pregnancies		
Leg swelling			# of deliveries		
Leg pain			# of miscarriages		
Nausea			abnormal bleeding		
Vomiting			vaginal bleeding		
Diarrhea			history of VD		
Constipation			sexual problems		
Black stools					
Rectal bleeding					
Change in bowel habits					
hemorrhoids					