Patient Medical/Health Questionnaire

Patient Name: _____ Date of Birth: _____/_____/_____

- Are you allergic to any medications? Yes ◯ No ◯ if yes, please list allergy and reaction:
  _____
- Medications you currently take with strength and how often taken (example: Metformin 500mg once a day for diabetes)
  - _____ Reason Taken: _____
  - _____ Reason Taken: _____
  - _____ Reason Taken: _____
  - _____ Reason Taken: _____
  - _____ Reason Taken: _____
  - _____ Reason Taken: _____

  Use the back of this page for additional space.
- Have you had any surgeries? If so, please list type of surgery, place and year: _____
  _____
- Family History:
  - Mother
    - Age: _____ Living // Deceased
    - Any major medical issues or psychiatric history: _____
      _____
  - Father
    - Age: _____ Living // Deceased
    - Any major medical issues or psychiatric history: _____
      _____
  - Sister(s) and/or Brother(s)
    - Sister(s): Age(s): _____ Living // Deceased
    - Brother(s): Age(s): _____ Living // Deceased
    - Any major medical issues or psychiatric history: _____
      _____
  - Maternal Grandparents
    - Grandmother: Age: _____ Living // Deceased
    - Grandfather: Age: _____ Living // Deceased
    - Any major medical issues or psychiatric history: _____
      _____
  - Paternal Grandparents
    - Grandmother: Age: _____ Living // Deceased
    - Grandfather: Age: _____ Living // Deceased
    - Any major medical issues or psychiatric history: _____
      _____
- Social History:
  - Highest level of education completed: _____
  - Marital Status: _____
  - Number of children: _____ Son(s): _____ Daughter(s): _____
  - Do you exercise? Yes ◯ No ◯ If yes, type of exercise *(ex: walking, running, etc)* _____
  - Are you sexually active? Yes ◯ No ◯
  - Do you drink alcohol? Yes ◯ No ◯ If yes, Number of drinks _____ per day // week.
  - Do you use tobacco products? Yes ◯ No ◯ If yes, what type and how often: _____
  - Caffeine Intake: Number of drinks _____ per day.
  - Employed? Yes ◯ No ◯ Retired? Yes ◯ No ◯
  - Occupation? _____
  - Nature of work: Sedentary // Physical // Prolonged Standing // Highly Stressful
  - Duration of current profession: _____

Patient Name: _____ Date of Birth: ____/____/____

Review of Systems

- Constitutional
  - Fever Yes _____ No _____
  - Malaise (fatigue) Yes _____ No _____
  - Recent weight changes Yes _____ No _____
  - Change in appetite Yes _____ No _____
    - If yes, has appetite ____increased or _____ decreased.
- Eyes
  - Blurred vision Yes _____ No _____
  - Double vision Yes _____ No _____
  - Visual Changes Yes _____ No _____
- Ears/Nose/Throat/Mouth
  - Hearing Loss Yes _____ No _____
  - Tinnitus (ringing in ears) Yes _____ No _____
  - Nasal congestion Yes _____ No _____
  - Nasal discharge Yes _____ No _____
  - Sore throat Yes _____ No _____
- Respiratory
  - Cough Yes _____ No _____
  - Shortness of breath Yes _____ No _____
  - Chest tightness or pain Yes _____ No _____
  - Wheezing Yes _____ No _____
- Cardiovascular
  - Murmur Yes _____ No _____
  - Palpitations Yes _____ No _____
  - Edema Yes _____ No _____
- Gastrointestinal
  - Nausea/Vomiting Yes _____ No _____
  - Change in bowel habits Yes _____ No _____
  - Diarrhea Yes _____ No _____
  - Constipation Yes _____ No _____
  - Abdominal Pain Yes _____ No _____
  - Blood in stools Yes _____ No _____
- Genitourinary
  - Blood in urine Yes _____ No _____
  - Painful urination Yes _____ No _____
  - Urinary Urgency Yes _____ No _____
  - Burning Yes _____ No _____
  - Itching Yes _____ No _____
- Musculoskeletal
  - Joint Pain Yes _____ No _____
  - Joint stiffness or swelling Yes _____ No _____
  - Numbness or tingling sensation Yes _____ No _____
- Neurological
  - Weakness Yes _____ No _____
  - Seizures or Convulsions Yes _____ No _____
  - Migraine Headaches Yes _____ No _____
  - Numbness Yes _____ No _____
  - Loss of balance Yes _____ No _____
  - Paralysis Yes _____ No _____
  - Tremors Yes _____ No _____

Patient Name: _____ Date of Birth: _____/_____/_____

- Psychiatric
  - Difficulty concentrating Yes _____ No _____
  - Insomnia Yes _____ No _____
  - Changes in socializing Yes _____ No _____
  - Substance Abuse Yes _____ No _____
  - Anxiety Disorder Yes _____ No _____
  - Irritability or mood changes Yes _____ No _____
  - Suicidal thoughts or attempts Yes _____ No _____
  - Anxiety Yes _____ No _____
  - Depression Yes _____ No _____
  - Forgetfulness Yes _____ No _____
  - Nervousness Yes _____ No _____
  - Quality of sleep Normal _____ Abnormal _____
  - Previous use of psychotropic medications: List any psychiatric medications you have previously used: _____

    _____
- Integumentary
  - Change in skin color Yes _____ No _____
  - Change in hair or nails Yes _____ No _____
  - Itching Yes _____ No _____
  - Rash Yes _____ No _____
- Endocrine
  - Heat/Cold Intolerance Yes _____ No _____
  - Excessive Urination Yes _____ No _____
- Hematologic/Lymphatic
  - Anemia Yes _____ No _____
  - Easy bleeding or bruising Yes _____ No _____
  - Malaise or fatigue Yes _____ No _____
- FEMALE
  - Date of last menstrual period: _____/_____/_____
  - Menstrual pain or tensions Yes _____ No _____
  - Are you menopausal? Yes _____ No _____
  - Date of last mammogram: _____/_____/_____
  - Are you pregnant or breastfeeding? Yes _____ No _____
  - Date of last pap smear" _____/_____/_____