

PATIENT QUESTIONNAIRE

Patient's Name _____ Birth Date _____ Sex _____ S. M. LTP. W. D.
 Address _____ Tel. No. _____
 Insurance Co. _____ HMO Copay \$ _____ PPO Copay \$ _____ Referred By _____ Occupation _____
 Mail Claim To _____ Policy No. _____

Instructions: Put In Those Boxes Applicable To You And In The "Yes" Or "No" Space. If Lines Are Provided Write In Your Answer.

	Family History																
	Father	Mother	Brother				Sister				Spouse/ Partner	Children					
			1	2	3	4	1	2	3	4		1	2	3	4	5	6
Age (if Living)																	
Health (G) Good (B) Bad																	
Cancer																	
Tuberculosis																	
Diabetes																	
Heart Trouble																	
High Blood Pressure																	
Stroke																	
Epilepsy																	
Nervous Breakdown																	
Asthma, Hives, Hay Fever																	
Blood Disease																	
Age (At Death)																	
Cause Of Death																	

Personal History											
Have You Ever Had . . .	No	Yes	Have You Ever Had . . .	No	Yes	Have You Ever Had . . .	No	Yes	Have You Ever Had . . .	No	Yes
<input type="checkbox"/> Scarlet Fever			Jaundice			<input type="checkbox"/> Broken Bones <input type="checkbox"/> Cracked Bones					
Diphtheria			Epilepsy			Recurrent Dislocations					
Smallpox			Migraine Headaches			<input type="checkbox"/> Concussion <input type="checkbox"/> Head Injury					
Pneumonia			Tuberculosis			Ever Been Knocked Unconscious					
Pleurisy			Diabetes			<input type="checkbox"/> Food <input type="checkbox"/> Chemical <input type="checkbox"/> Drug Poisoning					
<input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Heart Disease			Cancer			Explain					
<input type="checkbox"/> Arthritis <input type="checkbox"/> Rheumatism			Colonoscopy / Sigmoidoscopy			Latex Sensitivity					
<input type="checkbox"/> Bone Disease <input type="checkbox"/> Joint Disease			<input type="checkbox"/> High <input type="checkbox"/> Low Blood Pressure			Chronic Fatigue Syndrome					
<input type="checkbox"/> Neuritis <input type="checkbox"/> Neuralgia			Nervous Breakdown			Any Other Disease					
<input type="checkbox"/> Bursitis <input type="checkbox"/> Sciatica <input type="checkbox"/> Lumbago			<input type="checkbox"/> Hay Fever <input type="checkbox"/> Asthma			Explain					
<input type="checkbox"/> Polio <input type="checkbox"/> Meningitis			<input type="checkbox"/> Hives <input type="checkbox"/> Eczema								
<input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> HIV			Frequent <input type="checkbox"/> Colds <input type="checkbox"/> Sore Throat			Weight: Now One Yr. Ago					
Anemia			Frequent <input type="checkbox"/> Infections <input type="checkbox"/> Boils			Maximum When					

Allergies											
Are You Allergic To . . .	No	Yes	Are You Allergic To . . .	No	Yes	Are You Allergic To . . .	No	Yes	Are You Allergic To . . .	No	Yes
<input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa Drugs			Any Other Drugs			Any Foods					
<input type="checkbox"/> Aspirin <input type="checkbox"/> Codeine <input type="checkbox"/> Morphine			Explain			Explain					
<input type="checkbox"/> Mycins <input type="checkbox"/> Other Antibiotics			Iodine Or Radiologic Dye								
<input type="checkbox"/> Tetanus <input type="checkbox"/> Antitoxin <input type="checkbox"/> Serums			Adhesive Tape			<input type="checkbox"/> Nail Polish <input type="checkbox"/> Other Cosmetics					

Surgery											
Have You Had Removed . . .	No	Yes	Have You Had Removed . . .	No	Yes	Have You . . .	No	Yes	Have You . . .	No	Yes
Tonsils			<input type="checkbox"/> Ovary <input type="checkbox"/> Ovaries			Had Hernia Repaired					
Appendix			Hemorrhoids			Had Any Other Operations					
Gall Bladder			Ever Have A Transfusion			Been Hospitalized For Any Illness					
Uterus			<input type="checkbox"/> Blood <input type="checkbox"/> Plasma			Explain					

X-Rays											
Ever Have X-rays Of . . .	No	Yes	Date	Disease Present							
Chest											
<input type="checkbox"/> Stomach <input type="checkbox"/> Colon											
Gall Bladder											
Extremities											
Back											
Mammogram											
Sigmoidoscopy / Barium Enema											
Other											

Review Of Systems

Do You Now Have Or Have You Ever Had . . .	No	Yes	Do You Now Have Or Have You Ever Had . . .	No	Yes
<input type="checkbox"/> Eye Disease <input type="checkbox"/> Eye Injury <input type="checkbox"/> Impaired Sight			Kidney <input type="checkbox"/> Disease <input type="checkbox"/> Stones		
<input type="checkbox"/> Ear Disease <input type="checkbox"/> Ear Injury <input type="checkbox"/> Impaired Hearing			Bladder Disease		
Any Trouble With <input type="checkbox"/> Nose <input type="checkbox"/> Sinuses <input type="checkbox"/> Mouth <input type="checkbox"/> Throat			Blood In Urine		
Fainting Spells			<input type="checkbox"/> Protein <input type="checkbox"/> Sugar <input type="checkbox"/> Pus <input type="checkbox"/> Other In Urine		
Convulsions			Difficulty In Urination		
Paralysis			Narrowed Urinary Stream		
Dizziness			Abnormal Thirst		
Headaches: <input type="checkbox"/> Frequent <input type="checkbox"/> Severe			Prostate Trouble		
Enlarged Glands			<input type="checkbox"/> Stomach Trouble <input type="checkbox"/> Ulcer		
Thyroid: <input type="checkbox"/> Overactive <input type="checkbox"/> Underactive <input type="checkbox"/> Enlarged			Indigestion		
Enlarged Goiter			<input type="checkbox"/> Gas <input type="checkbox"/> Belching		
Skin Disease			Appendicitis		
Cough: <input type="checkbox"/> Frequent <input type="checkbox"/> Chronic			<input type="checkbox"/> Liver Disease <input type="checkbox"/> Gall Bladder Disease		
<input type="checkbox"/> Chest Pain <input type="checkbox"/> Angina Pectoris			<input type="checkbox"/> Colitis <input type="checkbox"/> Other Bowel Disease		
Spitting Up Blood			<input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Rectal Bleeding		
Night Sweats			Black Tarry Stools		
Shortness Of Breath <input type="checkbox"/> Exertion <input type="checkbox"/> At Night			<input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea		
<input type="checkbox"/> Palpitation <input type="checkbox"/> Fluttering Heart			<input type="checkbox"/> Parasites <input type="checkbox"/> Worms		
Swelling Of <input type="checkbox"/> Hands <input type="checkbox"/> Feet <input type="checkbox"/> Ankles			<input type="checkbox"/> Any Change In Appetite <input type="checkbox"/> Eating Habits		
Varicose Veins			<input type="checkbox"/> Any Change In Bowel Action <input type="checkbox"/> Stools		
Extreme <input type="checkbox"/> Tiredness <input type="checkbox"/> Weakness			Explain		

Immunization - EKG

Have You Had . . .	No	Yes	Have You Had . . .	No	Yes
Smallpox Vaccination (Within Last 7 Years)			Polio Shots (Within Last 2 Years)		
Tetanus Shot (Not Antitoxin)			An Electrocardiogram		When
Hepatitis Vaccination					

Social History

Do You . . .	No	Yes	Do You Use . . .	Never	Occ.	Freq.	Daily
Exercise Adequately			Laxatives				
How?			Vitamins				
Awaken Rested			Sedatives				
Sleep Well			Tranquilizers				
Average 8 Hours Sleep (Per Night)			Sleeping Pills				
Have Regular Bowel Movements			Aspirins				
Sex - Entirely Satisfactory			Cortisone				
Like Your Work (Hours Per Day) <input type="checkbox"/> Indoors <input type="checkbox"/> Outdoors			Alcoholic Beverages				
Watch Television (Hours Per Day)			Tobacco: Cigarettes (Pks Per Day)				
Read (Hours Per Day)			<input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Chewing Tobacco				
Have A Vacation (Weeks Per Year)			<input type="checkbox"/> Snuff				
Have You Ever Been Treated For Alcoholism			<input type="checkbox"/> Other Drugs				
Have You Ever Been Treated For Drug Abuse			Appetite Depressants				
Recreation: Do You Participate In Sports Or Have Hobbies Which Give You Relaxation At Least 3 Hours A Week?			Thyroid Medication: <input type="checkbox"/> No <input type="checkbox"/> Yes, In Past <input type="checkbox"/> None Now				Now On Gr. Daily
			Have You Ever Taken:				
			<input type="checkbox"/> Insulin <input type="checkbox"/> Tablets For Diabetes <input type="checkbox"/> Hormone Shots <input type="checkbox"/> Tablets <input type="checkbox"/> No				

Women Only

Menstrual History . . .	No	Yes	Do You . . .	No	Yes
Age At Onset			Are You Regular: <input type="checkbox"/> Heavy <input type="checkbox"/> Medium <input type="checkbox"/> Light		
Usual Duration Of Period Days			Do You Have <input type="checkbox"/> Tension <input type="checkbox"/> Depression Before Period		
Cycle (Start To Start) Days			Do You Have <input type="checkbox"/> Cramps <input type="checkbox"/> Pain With Period		
Date Of Last Period			Do You Have Hot Flashes		
Pregnancies . . .	No	Yes	Do You . . .	No	Yes
Children Born Alive (How Many)			Still Born (How Many)		
Cesarean Sections (How Many)			Miscarriages (How Many)		
Prematures (How Many)			Any Complications		

Emotions

Are You Often . . .	No	Yes	Are You Often . . .	No	Yes
Depressed			Jumpy		
Anxious			Jittery		
Irritable			Is Concentration Difficult?		