Acct #	Patient Name:	Date of Birth :

Patient Medical Questionnaire

Please answer the following questions as accurately and thoroughly as possible. Thank you. .

List ALL medical conditions:

_____
_____
_____

List ALL hospitalizations and surgeries:

_____
_____
_____

List ALL allergies to medications and food:

_____
_____
_____

List EVERY medication you currently take:

_____
_____
_____
_____
_____
_____
_____
_____

List any illnesses that run in your family:

_____
_____
_____

Patient's Health Questions- Please DARKEN the CIRCLES that correspond to your answers

Cancer			**Genitourinary**		
Colon	*O No*	*O Yes*	Are you pregnant or hoping	*O No*	*O Yes*
Lung	*O No*	*O Yes*	Blood in Urine	*O No*	*O Yes*
Lymphoma	*O No*	*O Yes*	Kidney Stones	*O No*	*O Yes*
Skin	*O No*	*O Yes*			
Thyroid	*O No*	*O Yes*	**Hematologic/Lymphatic**		
			Anemia	*O No*	*O Yes*
Cardiovascular			Bleeding and Bruising	*O No*	*O Yes*
Chest pain/angina pectoris	*O No*	*O Yes*	Past Transfusion	*O No*	*O Yes*
Heart Trouble/High Blood Pressure	*O No*	*O Yes*			
Shortness of breath-Lying Down	*O No*	*O Yes*	**Integumentary** (skin)		
Shortness of breath-Walking	*O No*	*O Yes*	Rash or Itching	*O No*	*O Yes*
Swelling of extremities	*O No*	*O Yes*			
			Respiratory		
Constitutional			Chronic or frequent cough	*O No*	*O Yes*
Fatigue	*O No*	*O Yes*	Sleep Apnea	*O No*	*O Yes*
Fever	*O No*	*O Yes*	Snoring	*O No*	*O Yes*
Are YOU in good health generally?	*O No*	*O Yes*	Wheezing	*O No*	*O Yes*
Headaches	*O No*	*O Yes*			
Recent weight change	*O No*	*O Yes*	**Gastroenterology**		
			Abdominal Pain	*O No*	*O Yes*
			Heartburn	*O No*	*O Yes*

Ears/Nose/Throat/Mouth

Change in sense of smell	*O No*	*O Yes*
Chronic Sinus Problems	*O No*	*O Yes*
Ear discomfort/Drainage/aches	*O No*	*O Yes*
Hearing Loss	*O No*	*O Yes*
Mouth Sores	*O No*	*O Yes*
Nose Bleeds	*O No*	*O Yes*

Eyes

Double or blurred vision	*O No*	*O Yes*

Endocrinology

Diabetes	*O No*	*O Yes*
Heat or Cold Intolerance	*O No*	*O Yes*

Social History

Caffeine Intake	*O No*	*O Yes*
Chewing Tobacco	*O No*	*O Yes*
Use of street drugs	*O No*	*O Yes*
Alcohol Use	*O No*	*O Yes*

CHOOSE ONE:

Never Smoker	*O*
Current Smoker	*O*
Former Smoker	*O*

Are you experiencing **Pain** today	*O No*	*O Yes*
Have you **Fallen** within the past year (18 years and older)	*O No*	*O Yes*

Musculoskeletal

Back Pain	*O No*	*O Yes*
Difficulty in Walking	*O No*	*O Yes*

Psychiatric

Depression	*O No*	*O Yes*
Memory loss or confusion	*O No*	*O Yes*

Neurological

Head Injury	*O No*	*O Yes*
Light Headed or Dizzy	*O No*	*O Yes*
Numbness or Tingling Sensation	*O No*	*O Yes*
Smoking in household	*O No*	*O Yes*
Pets at home	*O No*	*O Yes*
Travel outside the US	*O No*	*O Yes*

per day_____ per week_____
per month_____

Packs per Day:_____
Years Quit: _____

If yes – on a scale of **1 to 10** What is level_____
If yes – who manages your pain _____

If yes - How many times_____
Was your fall(s) with injury *O No* *O Yes*

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I need.