

File #:

CONFIDENTIAL PATIENT QUESTIONNAIRE

Patient Full Name: _____ Date: _____

Past Medical History

What is the general state of your health in your opinion? ___excellent ___good ___fair ___poor.

What do you know of your delivery (check all that apply)? ___easy ___difficult ___vaginal ___cesarean ___forceps
___vacuum extractor ___mother smoked ___mother was on drugs/medications ___premature ___on time ___overdue
___other: _____

What vaccinations have you had? ___normal childhood vaccinations ___other ___not vaccinated ___don't know.

List all serious illnesses that you have had with approximate dates/ages: _____

List all injuries, trauma, accidents that you have had with approximate dates/ages that have not already been covered:

List all surgeries, operations, and hospitalizations with approximate dates/ages that have not already been covered:

Current Health Status

List all medications, non-prescription drugs, homeopathic remedies, herbs, vitamins and minerals that you are currently taking:

List all allergies that you are aware of, include drugs, food, pollen and other: _____

How much of the following products do you use/drink?

_____tobacco _____water
_____alcohol _____caffeine

Average hours of sleep: _____ is it ___regular ___irregular ___enough ___not enough

How old is your mattress? _____ What position do you sleep in? _____

Are you on a particular diet? _____ If so, what for? _____

When was your last medical exam? _____ Reason: _____

Are you at risk for any environmental hazards, illnesses or dangers? ___yes ___no ___don't know.

What do you do for exercise and leisure? _____

Social Health

What are the normal activities of your daily life/routine? _____

What is the level of stress in your life overall? ___none ___mild ___moderate ___high ___severe

How do you feel about your current situations and future? ___optimistic ___hopeful ___frustrated ___pessimistic

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Family Health History

List the age and health (or cause of death) of each immediate family member:

Father: _____

Mother: _____

Spouse: _____

Siblings: _____

Children: _____

Has there been any occurrence in any of your blood relatives of the following conditions (as far as you know)?

___ kidney problems ___ diabetes mellitus ___ heart problems ___ high cholesterol ___ high blood pressure ___ stroke

___ tuberculosis ___ cancer ___ arthritis ___ asthma ___ allergies ___ headaches ___ epilepsy ___ mental illness

___ symptoms like the ones you are here for ___ any other known hereditary conditions: _____

Review of Systems

Please mark any symptoms/conditions/problems that you have now or have had recently that have not already been discussed.

___ recent weight changes

___ general fatigue

___ fever

___ excessive sweating at night

___ skin problems

___ hair loss

___ headaches

___ fainting

___ dizziness/vertigo

___ eye problems

___ sinus problems

___ frequent colds

___ frequent nosebleeds

___ swollen glands

___ breast problems

___ difficulty breathing

___ spitting blood

___ high blood pressure

___ heart problems

___ pacemaker

___ chest pain

___ nausea/vomiting

___ trouble swallowing

___ change in bowel habits

___ constipation or diarrhea

___ abdominal pain

___ anorexia

___ frequent urination

___ urinary hesitancy

___ painful urination

___ incontinence

___ kidney stones

___ hepatitis

___ other liver problem

___ stroke

___ varicose veins

___ leg cramps

___ swollen feet/ankles

___ other swelling

___ clots in veins

___ muscle pain

___ joint pain

___ osteoporosis

___ weakness

___ seizures

___ epilepsy

___ paralysis

___ numbness

___ tingling

___ tremors

___ incoordination

___ anemia

___ easy bruising

___ easy bleeding

___ thyroid problems

___ excessive sweating

___ excessive thirst

___ nervous tension

___ depression

___ mood swings

___ alcoholism

___ psychiatric care

___ memory problems

___ STD

___ hernia

___ AIDS/HIV

___ Multiple Sclerosis

___ Fibromyalgia

___ Chronic Fatigue Syndrome

___ Parkinson's Disease

___ Polio

___ prosthesis

Males Only

___ testis pain

___ penile discharge

___ sexual dysfunction

___ prostate problem

Females Only

___ pregnancy

___ irregular menses

___ excessive bleeding

___ menstrual tension

___ bleeding between periods

___ menopause

Other

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information I have provided.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's or Authorized Person's Signature

Date