Please complete the following Medical Questionnaire

Patient Name: ______________________________ **Date of Birth:** ____________ **Date:** __________

Social History:

Single ______ Married ______ Separated ______ Divorced ______ Widowed ______ Domestic Partner ______

Are you Employed? Full time _____ Part time _____ Homemaker _______ Retired _______ Unemployed _______

What was or is your job? ____

Alcohol Beverages: How many drinks per day? ______ OR per Week? _______ OR Occasionally OR None

Tobacco Use? Yes ____ No ____ OR Cigarettes? Yes ____ No ____ How many pack a day? ____ If you quit, when? _____

Please check any of the following symptoms you've experienced in the last 12 months or since your last visit.

Constitutional:

- ☐ Fever
- ☐ Chills
- ☐ Feeling Poorly (Malaise)
- ☐ Feeling Tired (Fatigue)
- ☐ Recent Weight Gain (____ Lbs)
- ☐ Recent Weight Loss (____ Lbs)

Eyes:

- ☐ Eye Pain
- ☐ Red Eyes
- ☐ Eyesight Problems
- ☐ Discharge
- ☐ Dry Eyes
- ☐ Eyes Itch

ENT:

- ☐ Earache
- ☐ Loss of Hearing
- ☐ Nosebleeds (Epistaxis)
- ☐ Nasal Discharge
- ☐ Sore Throat
- ☐ Hoarseness

Respiratory:

- ☐ Shortness of Breath (dyspnea)
- ☐ Wheezing
- ☐ Cough
- ☐ Dyspnea on Exertion
- ☐ Orthopnea(shortness of breath when lying flat)
- ☐ PND (paroxysmal nocturnal dyspnea)

Cardiovascular:

- ☐ Chest Pain
- ☐ Palpitations
- ☐ Heart Rate is Fast
- ☐ Heart Rate is Slow
- ☐ Leg Claudication
- ☐ Lower Extremity Edema

Gastrointestinal:

- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Vomiting
- ☐ Melena (black, "tarry" stools)

Genitourinary:

- ☐ Dysuria (painful urination)
- ☐ Incontinence
- ☐ Genital Lesion (Male only)
- ☐ Hesitancy (Male only)
- ☐ Nocturia (Male only)
- ☐ Testicular Pain (Male only)
- ☐ Pelvic Pain (Female only)
- ☐ Dysmenorrhea (Female only)
- ☐ Vaginal Discharge(Female only)
- ☐ Abnormal Vaginal Bleeding (Female only)

Musculoskeletal:

- ☐ Arthralgia (pain in a joint)
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Limb Pain
- ☐ Limb Swelling

Skin:

- ☐ Skin Lesions
- ☐ Skin Wound
- ☐ Itching
- ☐ Change in a Mole
- ☐ Dry Skin
- ☐ An Unusual Growth

Neurological:

- ☐ Confused
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting (Syncope)
- ☐ Limb Weakness (Paresis)
- ☐ Difficulty Walking

Psychiatric:

- ☐ Suicidal
- ☐ Sleep Disturbances
- ☐ Anxiety
- ☐ Depression
- ☐ Change in Personality
- ☐ Emotional Problems

Endocrine:

- ☐ Proptosis (abnormal protusion)
- ☐ Hot Flashes
- ☐ Muscle Weakness
- ☐ Deepening of the Voice
- ☐ Feelings of Weakness
- ☐ Erectile Dysfuntion (Male only)

Heme/Lymph:

- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Swollen Glands
- ☐ Swollen Glands in the Neck

Please complete the following Medical Questionnaire

Patient Name: ______________________________ **Date of Birth:** ____________ **Date:** __________

Reason for Consultation or Visit: ____

Primary Care Physician: ____

Preferred Pharmacy (Please Include Street Name): ____________________ **Phone:** ________________

Past Surgical History: **Approx. Date:**

____ ______________

____ ______________

____ ______________

____ ______________

Other Past and Present Medical Conditions/Diseases: **Approx. Date of Diagnosis:**

____ ______________

____ ______________

____ ______________

____ ______________

Medications: Please list all of current medications including both prescription drugs and over-the-counter medications.

Name of Medication	Dose (Strength)	How often taken

(Use back of form for additional space)

Allergies: Are you allergic or sensitive to any medication? No _______ Yes _______ If so, please list them.

Name of Medication	Type of Reaction (Hives, Rash, ect.)

Family Health History:

Relation	Medical Problems and/or Cause of Death
Father	
Mother	
Brother(s)	
Sister(s)	
Spouse	
Children	