

## 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
<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
<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
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 Götter			<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	Are You Regular: <input type="checkbox"/> Heavy <input type="checkbox"/> Medium <input type="checkbox"/> Light	No	Yes
Age At Onset			Do You Have <input type="checkbox"/> Tension <input type="checkbox"/> Depression Before Period		
Usual Duration Of Period Days			Do You Have <input type="checkbox"/> Cramps <input type="checkbox"/> Pain With Period		
Cycle (Start To Start) Days			Do You Have Hot Flashes		
Date Of Last Period					
Pregnancies . . .	No	Yes		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?		