Patient Questionnaire

Patient's Name: ____________________

Past Medical History:

Medical Conditions: ____________ ____________ ____________

____________ ____________ ____________

Have you ever had or have now: (please check at right of each item)

	Yes	No	Year		Yes	No	Year
High blood pressure				Swollen or painful joints			
Rheumatic fever				Heart murmur			
Heart trouble				Pain or pressure in chest			
Shortness of breath				Frequent or severe			
Asthma				Chronic cough			
Dizziness or fainting spells				Tuberculosis			
Epilepsy				Cancer (specify)			
Disabling depression				Diabetes			
Excessive anxiety				Thyroid trouble			
Ulcer (stomach or intestinal)				Anorexia or bulimia			
Intestinal trouble				Mononucleosis			
Self-induced vomiting				Jaundice or hepatitis			
Hernia				Kidney disease			
Eye trouble besides glasses				Hematuria or blood in urine			
Hearing loss				Knee problems			
Shoulder dislocation				Neck injury			
Recurrent back pain				Arthritis			
Back injury				Ankle problems			
Broken bones				Attention deficit disorder			
Concussion				Other			

Previous Surgeries: ____________ ____________ ____________

Current Medications: ____________ ____________ ____________

____________ ____________ ____________

Vitamins or Nutritional (Herbal) Supplements: ____________ ____________

Allergies: Medication(s): Yes or No If yes, which medications? ____________________

Foods: Yes or No If yes, which foods? ____________________

Latex: Yes or No

Bee Stings: Yes or No

Seasonal: Yes or No

Women Only:

When was your first menstrual period? ______________________________

When was your last menstrual period? ______________________________

When was the longest time between your periods? ______________________________

History:

Married: Yes or No **Children: (Names and ages):** ______________________________

Occupation: ______________________________

Athletic Activities/Hobbies: ______________________________

Tobacco Use: Yes or No

If yes, [ ] Cigarettes (____ packs per day) [ ] Cigars [ ] Pipe [ ] Chewing Tobacco

Alcohol/Drug Use: Yes or No

If yes, what and how often: ______________________________

Do you exercise three or more times per week? [ ] Yes [ ] No

Do you use a seatbelt on a regular basis? [ ] Yes [ ] No

Family History:

Has any person, related by blood, had any of the following?

	Yes	No	Relationship
High blood pressure			
Stroke			
Cancer (type:)			
Sudden death before age 50			
Diabetes			
Glaucoma			
Blood or clotting disorder			
Alcohol/Drug abuse			
Psychiatric illness/suicide			
Arthritis (RA, OA, Gout)			
Mar fan syndrome			

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Physician Signature