Print Form

Name: _____

Please help the physician with your care by completing this questionnaire. Please circle or complete the appropriate answer. Thank you.

Past Medical History: None☐ Stomach Ulcers☐ hypertension☐ diabetes☐ heart disease☐ Heart attack☐ angina☐ seizures☐ depression☐ anxiety☐ kidney stones☐ migraines☐ COPD (chronic lung disease/emphysema)☐ asthma☐ stroke☐ congestive heart failure☐ Cancer☐ bleeding problems☐ anemia☐

Past Surgical History and year: None☐ tonsils☐____ appendix☐____ gallbladder☐____ Tubes tied☐____ hysterectomy☐____ hernia repair☐____ C-section☐____ Back surgery☐____ pacemaker☐____ heart bypass☐____ Other heart procedures (stent, balloon, valve☐____ Other_____

Social History:

Tobacco:☐non-smoker☐smoker ☐packs per day former smoker☐
Alcohol: none☐occasional☐daily binge drinker☐alcoholic☐recovered ☐coholic☐
Employment: employed☐not-employed☐retired☐disabled☐homemaker☐
Drug Use: none☐former user☐marijuana☐cocaine☐heroin/opiates☐other☐
Personal Info: married☐divorced☐single☐ widowed☐
Living: alone☐with family☐with roommate☐assisted living☐homeless☐nursing home☐

Family History:

Diabetes☐High Blood Pressure☐Heart Disease☐Asthm☐Cancer☐Elevated Cholesterol☐Stroke☐
Alzheimer's☐Depression/Mental Illness☐Chronic Lung Disease/emphysema☐Kidney Disease☐

Are You Experiencing any of the Following?

General: fever☐chills☐weight loss☐fatigue☐sleep disturbance☐

Ear/Nose/Throat: sore throat☐nasal drainage☐ear pain☐sinus pressure☐

Eye: blurred vision☐double vision☐eye redness☐eye pain☐chest pain☐

Heart/Lung: cough☐sputum☐shortness of breath☐

Gastroin testinal: abdominal pain☐nausea☐vomiting☐diarrhea☐black/bloody stool☐

Genital: genital pain☐discharge burning with urination bleeding☐going often☐

Skin: rash☐itching swelling☐laceration☐

Musculoskeletal: back pain☐neck pain☐other muscular pain☐

Neurological: headache☐loss of strength☐loss of sensation☐difficulty walking/talking☐confusion☐ seizure☐