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Patient Questionnaire

Name: _____ Age: _____ Date: _____

Medications: List all medications that you take and amounts, including over-the-counter medications (for example: Tylenol, vitamins, cold medicines, etc.).

List all Allergies: _____

Past Medical History: (circle, list dates)

- | | | |
|------------------------------------|--------------------|----------------|
| Hypertension (high blood pressure) | Migraine Headaches | Arthritis |
| Asthma | Cancer _____ | Diabetes |
| Lung Disease | Kidney Disease | Bone Fractures |
| Heart Disease | Stroke | Other _____ |

List Hospitalizations:

List Surgeries:

Women: List Number of Pregnancies _____, Number of Live Births _____, Age at 1st Pregnancy _____

Birth Control Used: _____

Last Menstrual Period: _____ Periods every _____ days for _____ days

Habits:

- Smoking: yes / no Amount X _____ years
- Alcohol: yes / no Amount _____
- Caffeine: yes / no What _____ How much _____
- Exercise: yes / no What _____ How often _____

Family Medical History: If yes, who?

- | | |
|-----------------|-------------------|
| Hypertension | Cancer _____ kind |
| Heart Disease | Colon Cancer |
| Kidney Disease | Breast Cancer |
| Stroke | Prostate Cancer |
| Aortic Aneurysm | Diabetes Mellitus |
| Glaucoma | Arthritis |

Social History:

- Marital History: S M D W (circle one) Pets: _____
- Occupation: _____ Spouse's Name/Occupation: _____
- Hobbies: _____
- Chief Support People: _____ Children's Name(s)/Location: _____

Preventative Medicine (circle tests you've had done and date done):

- | | |
|---|--------------------------------|
| Chest X-ray: _____ | Mammogram: _____ |
| Cholesterol: _____ | Pap Smear: _____ |
| Colonoscopy: _____ | (Dexa) Bone Scan: _____ |
| Flu Shot: _____ | Pneumonia Shot: _____ |
| EKG: _____ | Diphtheria Tetanus Shot: _____ |
| Hemoccults (check stools for hidden blood): _____ | |

HPI Location, quality, severity, duration, timing, context, modifying factors, associated signs and symptoms OR status of chronic disease		
ROS	nl	See Note
Const		
Eyes		
ENT/Mouth		
CV		
Resp		
GI		
GU		
Muse		
Skin/Breasts		
Neuro		
Psych		
Endo		
Hem/Lymph		
Allerg/Immun		