



2020 Hospital Drive, Suite 1
P.O. Box 338
Windom, MN 56101
507-831-1703

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:

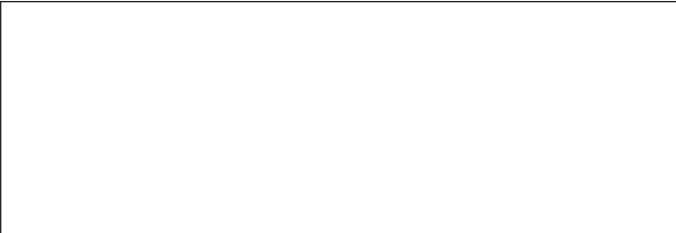
Marital History: S M D W (circle one)	Pets: _____
Occupation: _____	Spouse's Name/Occupation: _____
Hobbies: _____	Children's Name(s)/Location: _____
Chief Support People: _____	

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): _____	



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Patient Questionnaire

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		