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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.).

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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		