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PATIENT HISTORY QUESTIONNAIRE

Name_____ Age_____ Birth Date_____ Today's Date _____

Address _____ Phone _____

Occupation_____ Previous Occupation_____

List other Doctors treating you _____

_____ Who referred you to this office? _____

Please list all medicines that you are currently taking:

Medicine	Dose	Frequency	For What Illness?

Are you allergic to any medicines or foods? ❑ Yes ❑ No If yes, list: _____

_____

List all past operations and serious illnesses:

Operation or Illness	Month and Year	City, State	Outcome

Have you ever been advised to have any surgical operation which has not been done? ❑ Yes ❑ No If yes, explain: _____

_____

_____

Do you have a Living Will (Advanced Medical Directives)? ❑ Yes ❑ No
If no, would you like information regarding Living Wills? ❑ Yes ❑ No

Do you smoke cigarettes? ❑Yes ❑ No How much?_____When did you stop?: _____
How much before stopping? _____

Do you drink alcohol? ❑ Yes ❑ No How Much?_____When did you stop?: _____
How much before stopping? _____

Have you ever used any street drugs or illicit drugs? _____

How physically active are you? _____

FAMILY HISTORY: Age State of Health Age at Death Cause of Death

Father: _____

Mother: _____

Brother/Sister (state which): _____

Has any blood relative ever had:

Tuberculosis ❑ Yes ❑ No Relative _____
Heart Trouble ❑ Yes ❑ No Relative _____
Stroke ❑ Yes ❑ No Relative _____
Cancer ❑ Yes ❑ No Relative _____
Diabetes ❑ Yes ❑ No Relative _____
High Blood Pressure ❑ Yes ❑ No Relative _____
Epilepsy ❑ Yes ❑ No Relative _____

HAVE YOU EVER HAD:

Heart Attack ❑ Yes ❑ No
Heart Murmur ❑ Yes ❑ No
Leaky Heart ❑ Yes ❑ No
Enlarged Heart ❑ Yes ❑ No
High Blood Pressure ❑ Yes ❑ No
Rheumatic Fever ❑ Yes ❑ No
Tuberculosis ❑ Yes ❑ No
Valley Fever ❑ Yes ❑ No
Diabetes ❑ Yes ❑ No
Asthma ❑ Yes ❑ No
Cancer ❑ Yes ❑ No
Blood Clots ❑ Yes ❑ No
Gonorrhea or Syphilis ❑ Yes ❑ No
Nephritis ❑ Yes ❑ No
Jaundice - Hepatitis ❑ Yes ❑ No
Gall Bladder Disease ❑ Yes ❑ No
Anemia ❑ Yes ❑ No
Childhood Diseases ❑ Yes ❑ No
Scarlet Fever ❑ Yes ❑ No
Blood Transfusion ❑ Yes ❑ No
Stroke ❑ Yes ❑ No
Any others not listed: ❑ Yes ❑ No

_____
_____

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST TWO (2) YEARS:

Chest Pain ❑ Yes ❑ No
Pain in Arms or Throat ❑ Yes ❑ No
Wake Up Due to Chest pain ❑ Yes ❑ No
How Many Pillows Do You Sleep On? _____
Wake Up Due to Shortness of Breath ❑ Yes ❑ No
Palpitations or Very Rapid Heart Rate ❑ Yes ❑ No
Skipped Heart Beats ❑ Yes ❑ No
High Blood Pressure ❑ Yes ❑ No
Leg Cramps When Walking ❑ Yes ❑ No
Leg Cramps When Lying Down ❑ Yes ❑ No
Varicose Veins ❑ Yes ❑ No
Swelling of Ankles ❑ Yes ❑ No
Heartburn ❑ Yes ❑ No
Recurrent Nosebleeds ❑ Yes ❑ No
Fainting Spells ❑ Yes ❑ No
Light-headedness on Standing Up ❑ Yes ❑ No
Double Vision ❑ Yes ❑ No
Severe Headaches ❑ Yes ❑ No
Coughed Up Phlegm ❑ Yes ❑ No
Coughed Up Blood ❑ Yes ❑ No
Persistent Hoarseness ❑ Yes ❑ No
Recurrent Skin Rashes ❑ Yes ❑ No
Numbness or Tingling of Hands or Feet ❑ Yes ❑ No
Change in Hair Texture ❑ Yes ❑ No
Change in Weight ❑ Yes ❑ No
Nausea or Vomiting ❑ Yes ❑ No
Vomited Blood or "Coffee Ground Material" ❑ Yes ❑ No
Black Bowel Movements ❑ Yes ❑ No
Blood in Bowel Movements ❑ Yes ❑ No
Clay-colored Bowel Movements ❑ Yes ❑ No
Abdominal Cramping ❑ Yes ❑ No
Colitis ❑ Yes ❑ No
Pain While Urinating ❑ Yes ❑ No
How often do you get up at night to urinate? ❑ Yes ❑ No
Number of times _____
Difficulty in Starting Urination ❑ Yes ❑ No
Blood in Urine ❑ Yes ❑ No
Lose Urine When Coughing or Sneezing ❑ Yes ❑ No
Discharge from Penis ❑ Yes ❑ No
Swelling of any Joints ❑ Yes ❑ No
Have you had any X-rays of stomach or colon in past 10 years? ❑ Yes ❑ No
Have you had any X-rays of gallbladder in past 10 years? ❑ Yes ❑ No
Discoloration of Fingers when Exposed to Cold ❑ Yes ❑ No
Any others not listed: ❑ Yes ❑ No

_____
_____

FOR WOMEN ONLY:

Date of last Pap: _____
Age at onset of menstruation: _____
Onset date of last period: _____
Number of days between periods: _____
Number of days of flow? _____ Heavy? ❑ Yes ❑ No
Method of Birth Control: _____
Age at onset of intercourse: _____
Age at menopause: _____
Abnormal Paps? _____

Check which of the following you have had:

1. Breast Biopsy ❑ Yes ❑ No Year Done _____
2. Breast Implants ❑ Yes ❑ No Year Done _____
3. Mammogram ❑ Yes ❑ No Year Done _____
4. Breast Surgery ❑ Yes ❑ No Year Done _____
5. Colposcopy ❑ Yes ❑ No Year Done _____
6. Cone Biopsy ❑ Yes ❑ No Year Done _____

PREGNANCIES:

Total number of pregnancies: _____
Number of live births: _____
Number of prematures: _____
Number of miscarriages: _____ Stillbirths: _____
Number of abortions: _____
Number of living children: _____
Any complications? ❑ Yes ❑ No If Yes, what? _____

Has a blood relative had breast cancer? ❑ Yes ❑ No

Relationship: _____

Date of last mammogram: _____

Do you perform breast self exam? ❑ Yes ❑ No

Other important information: _____

_____

_____