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PATIENT QUESTIONNAIRE

Date: _____

CHIEF COMPLAINT and HISTORY OF ILLNESS:

1. What is the reason for today's visit? _____
2. How long have you had this problem? _____
3. How severe is this problem? (circle) 1 2 3 4 5 6 7 8 9 10
Mild very severe
4. Is the severity changing over time? (check) better stable worse
5. How often does this problem occur? (check) constant comes and goes
6. What makes it better? _____
7. What makes it worse? _____
8. What other symptoms are you having? _____

PAST MEDICAL HISTORY (please check any medical conditions you have):

- | | | | |
|--|--|--|---------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma/Enphysema | <input type="checkbox"/> Rheumatic fever | Others: _____ |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stroke, mini-stroke | <input type="checkbox"/> Sinusitis | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease/Angina | <input type="checkbox"/> Peptic Ulcers | _____ |
| <input type="checkbox"/> Neck/Back disease | <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Thyroid Disease | _____ |

PAST SURGICAL HISTORY (please check any surgeries you have had):

- | | | | |
|---|--|--|---------------|
| <input type="checkbox"/> Heart bypass/valve | <input type="checkbox"/> Gall bladder | <input type="checkbox"/> High Blood Pressure | Others: _____ |
| <input type="checkbox"/> Coronary angioplasty | <input type="checkbox"/> Lung surgery | <input type="checkbox"/> Colon removal | _____ |
| <input type="checkbox"/> Cartoid artery surgery | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Appendix removal | _____ |
| <input type="checkbox"/> Vascular bypass | <input type="checkbox"/> Back surgery | <input type="checkbox"/> Eye surgery | _____ |
| <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Brain surgery | <input type="checkbox"/> Tonsillectomy | _____ |
| <input type="checkbox"/> Heart transplant | <input type="checkbox"/> Liver transplant | <input type="checkbox"/> Kidney transplant | _____ |

PAST EYE SURGICAL HISTORY (please list any EYE surgeries you have had):

MEDICATIONS (list all your current medications and the dose you take):

- | | |
|-----------------------------|------------|
| Medication _____ | Dose _____ |
| Medication _____ | Dose _____ |
| Medication _____ | Dose _____ |
| Medication _____ | Dose _____ |
| Medication _____ | Dose _____ |
| Medication _____ | Dose _____ |
| Eye drops or ointment _____ | Dose _____ |
| Vitamins _____ | Dose _____ |
| Herbal Supplements _____ | Dose _____ |

Do you take Aspirin or Ibuprofen? Yes No
Do you take Warfarin (Coumadin)? Yes No
Have you taken steroids within the past year? Yes No

ALLERGIES (List medications/foods you are allergic to and what happens when you take them):

Medication _____ Reaction _____
Food (shellfish, etc.) _____ Reaction _____
Other (IV contrast, etc.) _____ Reaction _____

FAMILY HISTORY (Check all illnesses that run in your family):

Vision loss Alcoholism Heart attack Others: _____
 High blood pressure Psychiatric illness Cancer _____
 Sickle cell anemia Bleeding problems Diabetes _____
 Poor circulation Anesthesia reaction Stroke _____

SOCIAL HISTORY:

Occupation _____

Marital Status: Single Divorced Widowed Married
 Domestic Partner

How many children do you have? _____

Have you ever smoked? Yes No (cigarettes, cigar, pipe)

How much and for how long have you smoked? _____ packs per day for _____ years.
Quit? Y N If yes, when did you quit? _____

How much alcohol do you drink each day? _____

List any illicit drugs you currently use: _____

Do you have any current or past drug addictions? Yes No

REVIEW OF SYMPTOMS (Check all symptoms you have had either now or in the past):

CONSTITUTIONAL:

Weight loss _____ pounds in the past _____ weeks Fever, chills

NEUROLOGICAL:

Stroke Ministroke Temporary loss of vision or speech control
 Loss of sensation Facial paralysis Paralysis of an arm or leg

EYES:

Double Vision Loss of vision Eye(s) affected?(circle) right eye left eye both eyes
 Eye swelling Eye pain

Ears, Nose, Throat:

Hearing loss Sore throat
 Ear pain Dizziness

CARDIOVASCULAR/PULMONARY:

Chest pain Heart Attack Irregular heartbeat
 Poor circulation Leg pain during walking Coughing up blood
 Shortness of breath Asthma

GASTROINTESTINAL:

- Stomach ulcers
- Nausea/vomiting
- Diarrhea/Constipation
- Blood in stool
- Trouble swallowing
- Abdominal pain

GENITOURINARY:

- Blood in urine
- Pain during urination
- Difficulty making urine

MUSCULOSKELETAL:

- Neck/Spine surgery
- Neck or back disorder
- Arthritis

SKIN:

- Skin cancers
- Allergy to medical tape, iodine, or latex

PSYCHIARIC:

- Clinical depression
- Schizophrenia
- Anxiety
- Hallucinations
- Other psychiatric disorder (list) _____

INFECTIOUS DISEASE:

- Hepatitis
- HIV/AIDS
- Tuberculosis