ESTABLISHED PATIENT QUESTIONNAIRE

PLEASE PRINT

Full name:_____Age:_____

Preferred Contact Number_____

Email Address_____

Please list the 2 main health issues you would like to address during your visit today:

1) _____ 2)_____

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING

Name	Dosage	Times/day	Treatment for what condition	1st prescribed

PLEASE LIST ALL OVER THE COUNTER MEDICATIONS THAT YOU ARE CURRENTLY TAKING Including vitamins and herbal medications

Name	Dosage	Times/day	Treatment for what condition	1st prescribed

PHYSICIAN NOTES SECTION - HPI

ALLERGIES

Please list any medications or products you have taken which cause a <u>true</u> allergic reaction (hives, itching, rash, or difficulty breathing):_____

_____

HAVE YOU HAD ANY CHANGES IN YOUR MEDICAL OR SURGICAL HISTORY IN THE PAST YEAR?

Please describe:

OB/GYN HISTORY

Number of pregnancies? _____ Was your uterus removed? □ Yes □ No

Why?_____

Have your ovaries been removed? □ Yes □ No If yes, why?_____

HAVE YOU HAD ANY CHANGES IN YOUR FAMILY HISTORY

Please describe:

SOCIAL HISTORY

Current employment status: □ Disabled □ Part time □ Full time □ Retired □ Self-employed □ Other

What type of occupation do you (or did) you have?

Where do you live? □ Home □ Apt □ Assisted Living □ Other _____ City:_____

Current marital status? □ Single □ Married □ Separated □ Divorced □ Widowed □ Other

HABITS

Have you ever smoked cigarettes regularly? □ Yes □ No If yes, how many packs per day? (avg)_____

How many years?_____ Are you still smoking? □ Yes □ No

If no, when did you stop?_____

Do you drink alcohol? □ Yes □ No How many beers daily? _____

How many mixed drinks or glasses of wine daily?_____

Do you have any drug, nicotine or alcohol habits which concern you? □ Yes □ No

Do you exercise? □ Yes □ No Type _____

Days per week exercise performed _____Minutes per session _____

LIST A DAY OF YOUR USUAL DIET

Breakfast	Lunch	Dinner	Snacks (what hour)

SEXUAL HEALTH

Are you sexually active? □ Yes □ No

If yes, are you satisfied with your current sexual experiences? □ Yes □ No

If no, what portion are you not satisfied with? □ Sex drive □ Orgasm □ Arousal □ Lubrication

Do you experience pain with intercourse? □ Yes □ No

Does your partner have any sexual difficulties? □ Yes □ No

Other?_____

Sexual health scale (0 not good 10 excellent)

0 1 2 3 4 5 6 7 8 9 10

MENTAL AND EMOTIONAL HEALTH

Do you feel emotionally balanced? □ Yes □ No

What are your primary sources of stress?_____

Who is your biggest support group in times of stress? □ Immediate family □ Friends □ Spouse

Emotional health scale (0 not good 10 excellent)

0 1 2 3 4 5 6 7 8 9 10

SOCIAL HEALTH

Do you have questions or concerns about Advanced Directives or a Living Will? □ Yes □ No

If yes, please describe:_____

Please list which documents you currently have:_____

HEALTH MAINTENANCE

When was your last mammogram_____Location performed_____

Was a breast procedure performed_____

When was your last pap smear_____Location performed_____

Was a biopsy or other procedure was performed:_____

When was your last bone densitometry_____Location performed_____

What was the result_____

When was your last colonoscopy_____Performing doctor_____

Were colon polyps ever found_____

IMMUNIZATIONS

TYPE			
Tetanus booster	**YEAR**	**TYPE**	**YEAR**
Tetanus, diphtheria, (Tdap)		Tetanus, diphtheria	
Flu vaccine		Pneumonia vaccine	
HPV vaccine		Hepatitis B	
Eye exam		Shingles vaccine	

REVIEW OF SYSTEMS

Please check any of the following symptoms or problems you are currently experiencing. If the problem has been resolved, leave it blank. If you are unsure, place a question mark (?) by the medical issue.

General □ Changes in weight □ Trouble getting to sleep □ Trouble staying asleep □ Any issues affecting quality of sleep □ Headaches **Eyes** □ Changes in vision	**Nose/Throat** □ Earaches □ Hearing problems □ Frequent sinus problems **Respiratory** □ Wheezing □ Shortness of breath	**Skin** □ Rash □ Excess facial hair/body hair □ Changes in moles
Hematological □ Frequent bruising □ Bleed easily	**Breast** □ New or unusual lumps □ Nipple discharge	**Urogenital** □ Incontinence □ Vaginal Dryness □ Pelvic Pain
Cardiovascular □ Chest pain or pressure □ Swelling of legs □ Rapid heartbeat	**Musculoskeletal** □ Muscle weakness □ Muscle or joint pain □ Joint swelling	**Gastrointestinal** □ Frequent diarrhea □ Nausea/Vomiting □ Constipation □ Heartburn
Neurological □ Dizziness or trouble walking □ Numbness □ Memory problems	**Psychiatric** □ Depression □ Anxiety	**Endocrine** □ Hair loss □ Excessive thirst □ Cold intolerance □ Hot flashes