PATIENT QUESTIONNAIRE - ADULT

Name: ________________________ DOB: ________________

Date: ________________ Referred from: ____________

Age: ________ Height: ____________ Weight (lbs):________ Sex: Male / Female

CHIEF COMPLAINT/HISTORY OF ILLNESS:

1. What is the reason for today's visit?________________________________
2. Have you sought legal advice for this problem? ❑ Yes ❑ No

PAST MEDICAL HISTORY (Please check any illnesses you have): ❑ None

Neurologic
- ❑ Alzheimer's disease
- ❑ Multiple sclerosis
- ❑ Bell's palsy
- ❑ Stroke/mini-stroke
- ❑ Parkinson's disease
- ❑ Seizures
- ❑ Migraines
- ❑ Chronic headaches

Eyes/Ear/Nose/Throat
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Hypothyroidism
- ❑ Hyperthyroidism
- ❑ Thyroid disease
- ❑ Laryngitis
- ❑ Recurrent tonsillitis
- ❑ Reflux
- ❑ Recurrent sinusitis
- ❑ Cholesteatoma
- ❑ Vasomotor rhinitis
- ❑ Otitis media/externa
- ❑ Allergic rhinitis
- ❑ Parotid swelling, recurrent
- ❑ Chronic cough
- ❑ Sleep apnea/snoring
- ❑ Otosclerosis
- ❑ Recurrent ear infections

Pulmonary/Cardiovascular
- ❑ High blood pressure
- ❑ Abnormal EKG/heart rhythm (____________)
- ❑ Heart aneurysm
- ❑ Carotid disease
- ❑ Coronary artery disease
- ❑ Asthma/Bronchitis
- ❑ Emphysema
- ❑ COPD
- ❑ Angina
- ❑ Heart disease
- ❑ Enlarged heart
- ❑ Peripheral vascular disease
- ❑ Valvular disease/murmur please specify ________________
- ❑ Congestive heart failure (CHF)
- ❑ High/low cholesterol (circle one)
- ❑ Heart attack
- ❑ Pneumonia
- ❑ Chronic cough

Musculoskeletal
- ❑ Rheumatoid arthritis
- ❑ Joint disease
- ❑ Gout
- ❑ Neck/back disease
- ❑ Autoimmune disease
- ❑ Carpal tunnel syndrome
- ❑ Anemia
- ❑ Arthritis

Infectious Disease
- ❑ Sexually transmitted disease please specify ________________
- ❑ Measles
- ❑ Mumps
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ AIDS
- ❑ Rubella
- ❑ Chicken pox
- ❑ Recurrent *Strep* infections

Endocrine/Psychiatric/Misc
- ❑ Diabetes- non-insulin dependent
- ❑ Diabetes – insulin-dependent
- ❑ Chronic fatigue
- ❑ Osteoporosis
- ❑ Schizophrenia
- ❑ Anxiety
- ❑ Attention Deficit Disorder
- ❑ Panic attacks
- ❑ Bipolar disorder
- ❑ Bleeding disorder
- ❑ Depression

Gastrointestinal/Genitourinary
- ❑ BPH
- ❑ Hiatal hernia
- ❑ Gall bladder disease
- ❑ Irritable bowel syndrome
- ❑ Kidney disease/stones
- ❑ Hepatitis (please specify _________)
- ❑ Peptic ulcer disease

❑ Cancer (including skin): ________________________________

❑ Skin condition (i.e., rosacea, psoriasis, eczema): ________________________

❑ Other: ____

PAST SURGICAL HISTORY (Please check any surgeries you have had): ❑ None

- ❑ Heart bypass/valve
- ❑ Coronary angioplasty
- ❑ Carotid artery surgery
- ❑ Vascular bypass
- ❑ Mastectomy
- ❑ Heart transplant
- ❑ Adenoidectomy
- ❑ Ear surgery
- ❑ Facial fracture repair
- ❑ Pacemaker placement
- ❑ Plastic surgery
- ❑ Gall bladder
- ❑ Lung surgery
- ❑ Joint replacement
- ❑ Back surgery
- ❑ Brain surgery
- ❑ Liver transplant
- ❑ Breast augmentation/reduct
- ❑ Facelift
- ❑ Hair transplant
- ❑ Rhinoplasty
- ❑ Thyroidectomy
- ❑ Prostate removal
- ❑ Colon removal
- ❑ Appendix removal
- ❑ Sinus surgery
- ❑ Tonsillectomy
- ❑ Kidney transplant
- ❑ Cataract surgery
- ❑ LASIK
- ❑ Hiatal hernia repair
- ❑ Septoplasty
- ❑ Turbinate reduction

Others:____________
____
____
____
____
____

- ❑ Hysterectomy
- ❑ Liposuction
- ❑ Sinus surgery
- ❑ Ulcer surgery

Describe any complications you had related to surgery: ________________________________
____

Describe any complications you had related to anesthesia: ❑ None ❑ Nausea ❑ Vomiting ____________
____

ALLERGIES (List medications/foods you are allergic to and what happens when you take them): ❑ None

a) Medication________________________Reaction________________________

b) Foods____Reaction______________________________________
c) Non Drug Allergies____
d) Do you have a history of anaphylaxis? ❑ Yes ❑ No
e) Do you have an allergy to latex? ❑ Yes ❑ No
f) Do you have a history of a transfusion reaction? ❑ Yes ❑ No

FAMILY HISTORY (Check all illnesses that run in your family): ❑ None

❑ Hearing loss
❑ High blood pressure
❑ Sickle cell anemia
❑ Poor Circulation
❑ Alzheimer's Disease
❑ Breast Cancer
❑ Colon polyps/cancer
❑ Gallbladder disease
❑ Osteoporosis
❑ Do not know family history
❑ Alcoholism
❑ Psychiatric illness
❑ Bleeding problems
❑ Anesthesia reaction
❑ Anxiety
❑ Other cancer (please specify: ______________________________________)
❑ COPD/emphysema
❑ High cholesterol
❑ Parkinson's disease
❑ Heart attack
❑ Cancer
❑ Diabetes
❑ Stroke
❑ Arthritis
❑ Coronary artery disease
❑ Melanoma
❑ Thyroid disease/cancer
❑ Migraines___________
❑ Allergies___________
❑ Others______________
____
❑ Asthma
❑ Mental illness

SOCIAL HISTORY:

Occupation /School :_________________________________Marital status: ❑Married ❑Single ❑Divorced ❑ Widowed
How many children do you have?__________________
Have you ever smoked? ❑ Yes ❑ No (❑ cigarettes, ❑ cigar, ❑ pipe) Do you chew tobacco? Yes No
How much, and for how long have you smoked? _______Packs per day for______years. Stopped when:___________
How many alcoholic beverages do you drink each day?____________________Stopped when:________________
List any recreational drugs you currently use:____
Do you have any drug addictions?____
How many caffeinated beverages do you consume in a day? ______________
What do you do for exercise? ________________________________ How often? ______________________
Do you have an advance directive? ❑ Yes ❑ No

<u>REVIEW OF SYSTEMS</u> (Check all symptoms you have had either now or in the past):

<u>CONSTITUTIONAL</u>

❑ Weight loss________pounds in the past _____weeks ❑ Fever, chills ❑ Night sweats ❑ **None**
❑ Fatigue ❑ Loss of appetite

<u>EYES:</u>

❑ Wears glasses
❑ Wears contacts
❑ Blindness
❑ Watery eyes
❑ Blurring of vision
❑ Swelling
❑ Dryness of eyes
❑ Eye pain
❑ Redness
❑ Itchy eyes
❑ Double vision
❑ Discharge
❑ Other: ____________________
❑ **None**

<u>ENT</u>:

❑ Allergies ❑ Ear pain ❑ Hearing loss ❑ Nosebleeds ❑ Snoring
❑ Bleeding gums ❑ Facial pain ❑ Heartburn ❑ Nose pain ❑ Sore throat
❑ Decreased/lost smell ❑ Gum disease ❑ Hoarseness ❑ Septal perforation ❑ Sores on lips/gums
❑ Dentures ❑ Facial pain ❑ Mouth sores ❑ Teeth problems ❑ Voice changes
❑ Difficulty swallowing ❑ Gum disease ❑ Nasal congestion ❑ Postnasal drip ❑ Throat pain
❑ Dizziness/vertigo ❑ Headaches ❑ Nasal discharge ❑ Rhinorrhea ❑ Bad breath/taste
❑ Ear drainage ❑ Hearing aids ❑ Nasal obstruction ❑ Ringing in ears/tinnitus
❑ **None**
❑ Other ____

<u>CARDIOVASCULAR</u>:

❑ Shortness of breath (at rest) ❑ Palpitations
❑ Shortness of breath (exertion) ❑ Chest pain/pressure
Other ____ ❑ **None**

Name: _______________________________________

PULMONARY/RESPIRATORY
❑ Cough ❑ Coughing blood (hemoptysis) ❑ Shortness of breath
❑ **None** ❑ Other: ______________________________

GASTROINTESTINAL:
❑ Abdominal pain ❑ Change in bowel habits ❑ Nausea and vomiting ❑ Diarrhea
❑ Vomiting blood (hematemsis) ❑ Use of antacids ❑ Blood in stool
❑ **None** ❑ Other: ______________________________

GENITOURINARY:
❑ Blood in urine (hematuria) ❑ Hesitancy ❑ Nocturia ❑ Wets bed (enuresis)
❑ **None** ❑ Other: ______________________________

MUSCULOSKELETAL:
❑ Back pain ❑ Neck pain ❑ Weakness
❑ **None** ❑ Other: ______________________________

SKIN:
❑ Acne ❑ Itching ❑ Birth marks ❑ Loss of hair ❑ Change in mole
❑ Skin rashes ❑ Dryness ❑ **None** ❑
Other:______________________________

NEUROLOGICAL:
❑ Memory loss ❑ Paralysis of arm or leg ❑ Speech difficulty ❑ Paresthesia
❑ Syncope ❑ Head trauma ❑ Near syncope ❑ Local weakness
❑ Numbness ❑ **None** ❑ Other:
____

PSYCHIATRIC:
❑ Disturbing thoughts/feelings ❑ Suicidal thoughts ❑ Hallucinations
❑ **None** ❑ Other: ______________________________

ENDOCRINE
❑ Heat or cold intolerance ❑ Thyroid nodule ❑ Hair loss ❑ Increased thirst
❑ **None** ❑ Other: ______________________________

HEMATOLOGY/LYMPHATIC: ❑ Abnormal bleeding ❑ Easy bruising ❑ **None**
❑ Are you currently being anticoagulated? ❑ Yes ❑ No ❑ Enlarged lymph nodes

ALLERGY/IMMUNOLOGY
❑ Itchy eyes ❑ Red eyes ❑ Sneezing ❑ Hayfever
❑ Itchy nose ❑ Swollen eyes ❑ Urticaria ❑ Eye discharge
❑ Rashes ❑ **None** ❑ Other:
____

DO YOU HAVE ANY IMPLANTABLE DEVICES? If so, what and where? ______________________________

MEDICATIONS (List all your current medications and the dose you take): ❑ None (please use back if needed)
Medication______________________________Dose______________________________
Medication______________________________Dose______________________________
Medication______________________________Dose______________________________
Do you take Aspirin or Ibuprofen? ❑ Yes ❑ No
Do you take Warfarin (Coumadin)/Plavix? ❑ Yes ❑ No Have you taken steroids within the past year? ❑ Yes ❑ No
Thank you for your cooperation

I have personally reviewed this history and review of systems

______________________________ ______________________________
Attending Physician Signature Date