PATIENT SURVEY

(Please Print Clearly)

DATE: _____

NAME: _____Date Of Birth ___/____/_____

MEDICAL HISTORY

Please provide us with an overview of issues that have been addressed by a medical professional.

_____
_____
_____
_____
_____

Are there any issues that you would like to discuss today that have not been addressed fully by another medical professional?

_____
_____
_____

Please list any surgeries you have had and when:

_____
_____

Were you ever hospitalized? Why and When?

_____
_____
_____
_____

List all prescription and non-prescription medications, dose, frequency, how long and who prescribes them?

_____
_____
_____
_____
_____
_____

Please go onto the back page if you need more space.

ALLERGIES

List allergies and sensitivities to medications as well as the reactions:

_____

_____

_____

_____

Do you have food allergies? List: _____

Reaction to insect bites? List: _____

Allergic to animals? List: _____

Seasonal allergies? List: _____

Other allergies? List: _____

SOCIAL HISTORY

What is your occupation? _____

How many years? _____

Marital Status: Single Married Divorced Widowed

What do you consider your stress level is? Low Moderate High

Travel outside the U.S. within the past three years? Yes No

Where and When? _____

On a scale of 1 – 5 (1 representing low use, 5 representing habitual use; please rate below)

CURRENT		PAST		
Alcohol use	_____	Alcohol use	____	Total years of alcohol use _____
Caffeine use	_____	Caffeine use	____	Total years of caffeine use _____
Tobacco use	_____	Tobacco use	____	Total years of tobacco use _____
Illegal Drug use	_____	Illegal Drug use	____	Type & Total yrs of drug use
Unsafe Sex	_____	Unsafe Sex	____	_____
Regular Exercise	_____	Regular Exercise	____	Type & Total yrs of exercise
				_____

Please circle any of the following if they apply:

CHEST PAIN
CHRONIC SINUS INFECTIONS
DIGESTIVE PROBLEMS
WHEEZING/ASTHMA
SKIN PROBLEMS
HEADACHES
FREQUENT FALLS
VOMITING BLOOD
ARTHRITIS/JOINT PAIN
TROUBLE WALKING
MENSTRUAL/VAGINAL
SEXUAL FUNCTION
BLOOD IN URINE
ANOREXIA/BULIMIA
ABDOMINAL PAIN
VOMITING
BLOOD IN STOOLS

STUTTERING

KIDNEY STONES
PALPATATIONS
URINARY PROBLEMS
SEIZURES
NOSE BLEEDS
SKIN MOLES
VISION
NIGHT SWEATS
PELVIC INFLAMMATION
EXCESSIVE THIRST
TESTICULAR PROBLEMS
BACK/NECK INJURIES
WEIGHT LOSS/GAIN
STD ISSUES/CONCERNS
COUGHING BLOOD
BREATHING
ATTENTION DEFICIT DISORDER
CHRONIC BLADDER INFECTIONS

DIZZINESS
FAINTING
CHRONIC FEVER
CHRONIC DIARRHEA
COUGH
MEMORY
HEARING PROBLEMS
COORDINATION
TEETH/GUM PROBLEMS
FEET/LEG SWELLING
HEMORRHOIDS
SWALLOWING/THROAT
OBESITY
APPETITE
FATIGUE
CONSTIPATION
TOURETTE'S SYNDROME

GERD

Are you currently experiencing any of the following? Please circle all that apply:

Loss of interest in things you used to enjoy
Chronic sadness
Problems concentrating/decision making
Restlessness, inability to sit still
Hopelessness
Thoughts of death/suicide
Feelings of worthlessness, guilt
Loss of energy/exhaustion
Changes in appetite
Other: Please list

_____

FOR FEMALES ONLY

First Day of Last Menstrual Period: _____/_____/_____

Length of period _____days; typical interval between periods _____days

Form of Birth Control: _____

Date of last Pap Smear: _____/_____/_____ Provider Name:_____

Date of last Mammogram: _____/_____/_____ Benign exam? Yes or No

Menopause? Yes or No

Recent pregnancy Yes or No; Miscarriages Yes or No; Live Births Yes or No; Terminations Yes or No

Please list any concerns if any: _____

PREVENTATIVE CARE

Please list the date of your most recent; if unknown please circle unknown:

Complete Physical	Unknown
Tubercolosis Test	Unknown
Tetanus Immunization	Unknown
Pneumonia Immunization	Unknown
Influenza Immunization	Unknown
Measles Immunization	Unknown
Hepatitis A and or B Immunization	Unknown
Varicella (Chicken Pox) Immunization	Unknown
Colonoscopy	Unknown
Dental Cleaning	Unknown

FAMILY HISTORY

Circle Living or	Deceased	Please list any inherited diseases, chronic illness or cause of death
LIVING	DECEASED	FATHER
LIVING	DECEASED	MOTHER
LIVING	DECEASED	PATERNAL GRANDFATHER
LIVING	DECEASED	PATERNAL GRANDMOTHER
LIVING	DECEASED	MATERNAL GRANDFATHER
LIVING	DECEASED	MATERNAL GRANDMOTHER
LIVING	DECEASED	BROTHERS
LIVING	DECEASED	SISTERS
LIVING	DECEASED	SONS
LIVING	DECEASED	DAUGHTERS

Have any of your family members had any of the following diseases? Please circle:

HEART DISEASE	HIGH BLOOD PRESSURE	MENTAL RETARDATION	ALCOHOL/DRUG ABUSE	HIGH CHOLESTEROL
EMPHYSEMA	MIGRAINE HEADACHES	SICKLE CELL ANEMIA	HEPATITIS	SEIZURES
ASTHMA	TUBERCULOSIS	DIABETES	SUICIDE	COLON POLYPS
MENTAL ILLNESS	BLINDNESS	ANXIETY	CANCER	ANEMIA
STROKE	ALLERGIES	KIDNEY DISEASE	THYROID DISEASE	DEAFNESS
DEPRESSION	LUNG DISEASE	ADHD	SUDDEN DEATH	