Health Information Questionnaire

Today's Date:_____ Primary Care Physician: _____ ID#:_____

Patient's Name: _____ Date of Birth:_____ Sex: M or F

Preferred Pharmacy:_____ Patient's Telephone Number:_____

What is the reason for your visit today?_____

What medications are you currently taking? (Attach list if necessary)

Medication:	Prescribed by:	Do you need a refill today?

Are you allergic to any medications? Yes No If yes, what medication?_____

What type of reaction did you have to this medication?_____

Are you currently pregnant or nursing?_____

Please check any symptoms below that you are currently experiencing:

Constitutional:

_____Fever/Chills
_____Feeling poorly
_____Feeling tired
_____Recent weight gain/loss
_____Night sweats
_____Marked morning pain/stiffness
_____Pain unrelieved by position or rest
_____Pain at night

Eyes:

_____Eye pain
_____Red eyes/discharge
_____Vision changes
_____Dry eyes
_____Itchy eyes

ENT:

_____Earache
_____Sore throat
_____Nasal congestion/discharge
_____Nosebleeds
_____Hoarseness
_____Hearing loss
_____Sore throat

Cardiovascular:

_____Chest pain
_____Irregular heart beats
_____Lower extremity edema
_____Leg cramps
_____Pain with exercise
_____ Slow heart rate
_____ Fast heart rate

Gastrointestinal:

_____Nausea and/or vomiting
_____ Abdominal pain
_____ Diarrhea
_____ Heartburn

Genitourinary:

_____Dark or bloody stool
_____ Pain with urination
_____Frequency/Urgency of urination
_____ Night time urination
_____Hesitancy
_____ Incontinence
_____Blood in urine
_____Genital lesion
_____Difficulty with menstrual periods
_____Erectile dysfunction
_____Prostate problems
_____ Taking birth control pills

Musculoskeletal:

_____ Joint pain
_____ Muscle pain
_____ Joint Swelling
_____ Joint Stiffness
_____ Limb pain/swelling
_____ Muscle cramps/weakness
_____ Osteoporosis
_____ Numbness in groin/buttocks

Integumentary:

_____ Skin rash
_____ Itching
_____ Skin lesions
_____ Change in a mole
_____ Breast pain/lump
_____ Wound/unusual growth on skin

Neurological:

_____ Headache
_____ Dizziness
_____ Mental changes
_____ Fainting
_____ Limb Weakness
_____ Difficulty walking
_____ Numbness
_____ Tremor
_____ Radiating pain

Psychiatric:

_____ Anxiety
_____ Depression
_____ Personality changes
_____ Sleep disturbances

Endocrine:

_____ Excessive thirst/urination
_____ Drooping of eyelid
_____ Hot or cold intolerance
_____ Hair loss
_____ Generalized weakness
_____ Corticosteroid use (Cortisone, Prednisone, etc.)

Blood/Lymph:

_____ Easy bruising/bleeding
_____ Swollen glands

Social History:

Do you use tobacco products:
YES NO PAST
Cigarettes per day? _____
How many years have or did you use tobacco? _____
Drink more than 2 alcoholic beverages per day? **YES NO**
Cups of coffee per day?_____
Do you use drugs for reasons that are not medical? If so, please list:
_____
_____
_____

(See additional questions, on back of form.)

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Patient Name:_____ Date of Birth:_____ID#:_____

Marital Status: □ Single □ Married □Divorced Number of Children: _____ Number of Pregnancies____

Family History:

Have any members of your immediate family (parents, siblings, grandparents, children) ever had:

Breast Cancer: □ Yes □ No If so, whom? _____
Colon Cancer: □ Yes □ No If so, whom? _____
Other types of cancer: □ Yes □ No If so, whom? _____
High Blood pressure: □ Yes □ No If so, whom? _____
Stroke: □ Yes □ No If so, whom? _____
Heart Problems: □ Yes □ No If so, whom? _____
Diabetes: □ Yes □ No If so, whom? _____
Rheumatoid Arthritis □ Yes □ No If so, whom? _____

Past Medical History:

Have you been treated for any of the following conditions? If so, please list approximate dates of treatment and treating physician.

Condition:	Approximate Dates of Treatment/ Treating Physician	Condition:	Approximate Dates of Treatment/ Treating Physician
Anemia		Lung Disease/Asthma	
Arthritis		Phlebitis	
Blood Disease		Psychological	
Cancer		Seizures	
Cholesterol		Stroke	
Diabetes		Thyroid Disease	
GI Disease		Weight gain/loss	
Genital/Urinary Disease		Serious Accident	
Heart Disease		Surgeries	
High Blood Pressure		Hospitalizations	
Liver Disease			

Please list any other relevant information or questions you may have for the physician today:

_____
_____
_____