Chart _____ Date____/____/____

Confidential Health Information Questionnaire

Patient Name _____ Birth Date _____/_____/_____ Gender: □ M □ F

Address _____

City _____ State _____ ZIP_____

Cell Phone _____ Home phone _____

Work Phone _____ Email _____

Family Physician _____ Phone _____

Social History

Marital Status: □ Married □ Separated □ Divorced □ Single

Spouse's Name _____ Spouse's Birth Date ____/____/____

Who do you live with: □ Alone □ Spouse □ Other _____

Tobacco Use: □ Never □ Former Smoker □ Current Smoker

On average how many alcoholic beverages do you drink each day: _____

On average how many cups of coffee, tea or cola do you drink each day: _____

On average how many days a week do you exercise for at least 30 minutes: _____

Occupational History

What kind of work do you do? _____ □ Retired □ Part-time □ Full-time

Who is your employer? _____

How long have you been doing this job? _____

Chart _____ Date____/____/____

Current Complaint

Briefly describe your current complaint _____

_____

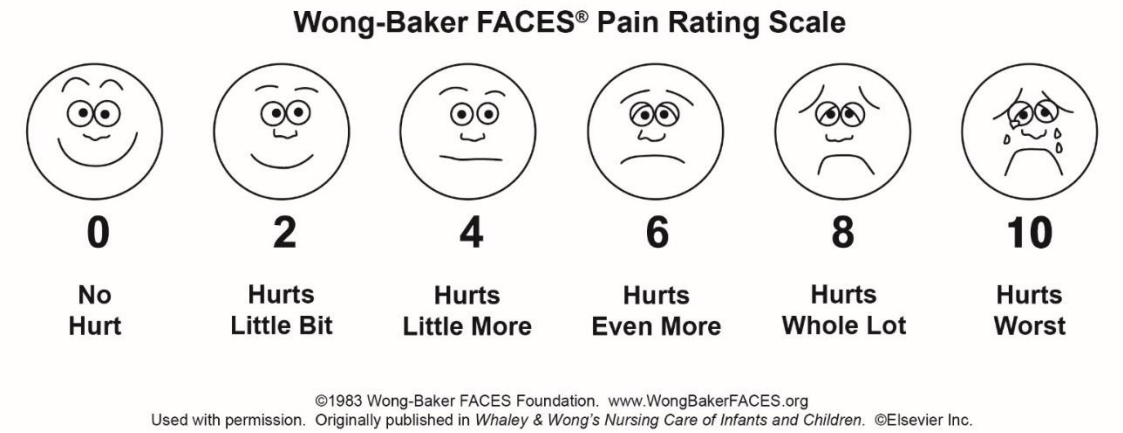
What do you think caused it? _____

Date the problem began _____/_____/_____ or □ Gradual Onset □ Chronic/Recurrent

How often are your symptoms present? □ 0-25% □ 25-50% □ 51-75% □ 76-100%

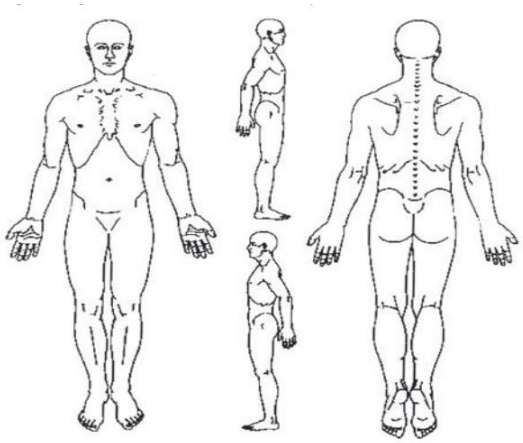
Is your condition: □ Getting Better □ Getting Worse □ Staying the Same

Please rate your pain intensity on the scale below:



Use the symbols below to indicate where and what type of discomfort you feel on the picture below:

Dull/Achy	*Numbness*	*Pins/Needles/Tingling*	*Stabbing*	*Burning*
XXXXXX	OOOOOO	……	//////	^^^^^^



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List pain-relievers taken within the last 12 hours: _____

List allergies to medications: _____

List any X-rays, MRIs or other tests that you have had for your complaint area in the past year:

Test _____ Where was it done _____

Test _____ Where was it done _____

Test _____ Where was it done _____

Please list all surgeries that you have ever had done or attach a separate list

Surgery _____ Date _____ Dr._____

Surgery _____ Date _____ Dr._____

Surgery _____ Date _____ Dr._____

Please list all medications that you currently take or attach a separate list

_____ dose _____ _____ dose _____

_____ dose _____ _____ dose _____

_____ dose _____ _____ dose _____

_____ dose _____ _____ dose _____

Family History

Have blood relatives of your immediate family (parents, grandparents, siblings, children) had any of the following conditions? Choose yes or no. If yes list their relationship to you (e.g. mother).

Cancer: □ Yes □ No If yes, then who _____

Diabetes: □ Yes □ No If yes, then who _____

Heart disease: □ Yes □ No If yes, then who _____

Stroke: □ Yes □ No If yes, then who _____

Kidney Disease: □ Yes □ No If yes, then who _____

Chart _____ Date____/____/____

Review of Systems: Please check Yes or No to All below

Constitutional

Yes	No	
□	□	Excessive Fatigue
□	□	Frequent Fevers
□	□	Trouble sleeping
□	□	Unintended weight gain/loss

Eyes

Yes	No	
□	□	Blurred vision
□	□	Double vision
□	□	Loss of vision

Ears, Nose, Mouth, & Throat

Yes	No	
□	□	Loss of sense of smell
□	□	Hearing loss
□	□	Ringing in your ears

Cardiovascular & Respiratory

Yes	No	
□	□	Chest pain
□	□	Palpitations
□	□	Shortness of breath

Gastrointestinal

Yes	No	
□	□	Frequent constipation or diarrhea
□	□	Frequent heartburn
□	□	Frequent nausea
□	□	Frequent vomiting

Bladder & Sexual Function

Yes	No	
□	□	Discomfort/burning
□	□	Loss of bladder control
□	□	Loss of desire for sex
□	□	Menopause (women)
□	□	Trouble with erection (men)
□	□	Urgency to urinate

Skin

Yes	No	
□	□	Change in hair or nails
□	□	Change in skin color
□	□	Persistent itching

Endocrine

Yes	No	
□	□	Hot/cold intolerance
□	□	Increased thirst
□	□	Loss of hair

Memory, Thinking, Mood, Psychiatric

Yes	No	
□	□	Anxiety or depressed mood
□	□	Hallucinations
□	□	Memory loss

Blood and Lymph

Yes	No	
□	□	Anemia
□	□	Easy bruising/bleeding
□	□	Slow to heal from cuts

Neurological

Yes	No	
□	□	Confusion
□	□	Falling down
□	□	Headaches
□	□	Loss of coordination
□	□	Involuntary movements/tremors
□	□	Lightheaded/dizzy/spinning/vertigo
□	□	Fainting or passing out
□	□	Numbness
□	□	Seizure or convulsion
□	□	Tingling
□	□	Trouble speaking
□	□	Trouble walking
□	□	Weakness
□	□	Trouble swallowing

By signing below, you attest that the information you have provided is correct and complete, and you are giving your consent to be examined in our practice.

_____ _____/_____/_____

Signature of patient (parent/guardian if minor) Date

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