

# Medical Questionnaire

*Please fill out both sides of this form, use blue or black ink, and sign on the back.*



Today's date: \_\_\_\_\_ Date of appointment: \_\_\_\_\_

Patient Name: Last		First	Middle Initial
Date of birth		Age	Soc. Sec. No.
Referring phys./how did you hear about us?		Primary care phys.	
What problem are you seeing the doctor for today?		When did your symptoms begin?	
Have you been treated for this problem in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, when?			
Other Medical Conditions for which you are being treated: (Please check all that apply.)			
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Stroke <input type="checkbox"/> High cholesterol
<input type="checkbox"/> Liver disease	<input type="checkbox"/> Lung disease	<input type="checkbox"/> Vascular disease	<input type="checkbox"/> Diabetes <input type="checkbox"/> Other (list below)
Other conditions for which you have been in the hospital or are receiving treatment by a physician:			
<input type="checkbox"/> I take no medicines, or list medications: (include over the counter medications and prescriptions) Please include the dosage you take.			
1.	4.		
2.	5.		
3.	6.		
<input type="checkbox"/> I have no allergies to medicines, or list allergies to medicines that you cannot take, with reactions, too.			
1.	3.		
2.	4.		
Who lives in the house with you?			
Your occupation -			
Are you <input type="checkbox"/> Married? <input type="checkbox"/> Single? <input type="checkbox"/> Divorced? <input type="checkbox"/> Widowed?			
Tobacco use (includes snuff, cigars, chewing tobacco, cigarettes, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No Usage: (packs/day, cigarettes/day, cans of snuff/day, etc.)			
Alcohol use: <input type="checkbox"/> Yes <input type="checkbox"/> No How much, how often?			
If female, are you PREmenopausal or POSTmenopausal? (Please circle one) Are you pregnant? Could you be pregnant?			
<input type="checkbox"/> I've had no previous surgeries, or list previous surgeries in columns below:			
Type of surgery	Complications?	Location/hospital	Date

**OVER**

Patient Name \_\_\_\_\_

Date of birth \_\_\_\_\_

Please **check** all of the following symptoms that you have experienced in the last 6 months:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Abdominal pain           | <input type="checkbox"/> Blood clots in your legs                     | <input type="checkbox"/> Blurred vision                   |
| <input type="checkbox"/> Abnormal bleeding        | <input type="checkbox"/> Leg cramps when walking                      | <input type="checkbox"/> Dizziness                        |
| <input type="checkbox"/> Appetite loss            | <input type="checkbox"/> Numbness                                     | <input type="checkbox"/> Hearing loss                     |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Swelling of your legs                        | <input type="checkbox"/> Migraines / Persistent headaches |
| <input type="checkbox"/> Black/Tarry stools       |   | <input type="checkbox"/> Mini-strokes                     |
| <input type="checkbox"/> Blood in stool           | <input type="checkbox"/> Chest pain                                   | <input type="checkbox"/> Sudden loss of vision in one eye |
| <input type="checkbox"/> Constipation             | <input type="checkbox"/> Irregular heart beat                         |   |
| <input type="checkbox"/> Diarrhea                 | <input type="checkbox"/> Loss of consciousness                        | <input type="checkbox"/> MRSA    Date: _____              |
| <input type="checkbox"/> Fever                    | <input type="checkbox"/> Rapid heart beat                             | Other: _____  |
| <input type="checkbox"/> Irregular menses         | <input type="checkbox"/> Shortness of breath                          | _____   |
| <input type="checkbox"/> Muscle pain              |   | _____   |
| <input type="checkbox"/> Nausea / Vomiting        | <input type="checkbox"/> Enlarged lymph nodes                         | _____   |
| <input type="checkbox"/> Pain during sex          | <input type="checkbox"/> Persistent cough                             | _____   |
| <input type="checkbox"/> Painful urination        | <input type="checkbox"/> Sore throat / Hoarseness                     | _____   |
| <input type="checkbox"/> Penile/Vaginal discharge |   | _____   |
| <input type="checkbox"/> Voiding frequently       | <input type="checkbox"/> Nasal discharge                              |   |
| <input type="checkbox"/> Weakness                 | <input type="checkbox"/> Nose bleeds                                  |   |
| <input type="checkbox"/> Weight loss              | <input type="checkbox"/> Redness of the eyes / Drainage from the eyes |   |

Do you have a family history of (circle all that apply):  
Heart disease?      High blood pressure?      Cancer? If so, what type of cancer?  
Stroke?      Diabetes?

X \_\_\_\_\_ Date \_\_\_\_\_  
Patient's (or authorized person's) signature

Physician notes only:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

X \_\_\_\_\_ Date \_\_\_\_\_  
Physician's signature

Information updated and reviewed by: \_\_\_\_\_ Date \_\_\_\_\_  
(TSC Employee)

For use by medical assistant or physician only:  
Blood Pressure:    R                      L                      Respirations:                      Pulse :  
Current Height:                      Current Weight: