

# PATIENT QUESTIONNAIRE

## CONDITIONS

Place an "X" in boxes you have now or have had in the past.

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> AIDS<br><input type="checkbox"/> Alcoholism<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Anorexia<br><input type="checkbox"/> Appendicitis<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Bleeding disorders<br><input type="checkbox"/> Breast Lump<br><input type="checkbox"/> Bronchitis<br><input type="checkbox"/> Bulimia<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Cataracts<br><input type="checkbox"/> Chemical dependency<br><input type="checkbox"/> Chicken pox | <input type="checkbox"/> Diabetes<br><input type="checkbox"/> Emphysema<br><input type="checkbox"/> Epilepsy<br><input type="checkbox"/> Fractures<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Goiter<br><input type="checkbox"/> Gonorrhea<br><input type="checkbox"/> Gout<br><input type="checkbox"/> Heart disease<br><input type="checkbox"/> Hepatitis<br><input type="checkbox"/> Hernia<br><input type="checkbox"/> Herpes<br><input type="checkbox"/> High cholesterol<br><input type="checkbox"/> HIV positive<br><input type="checkbox"/> Kidney disease | <input type="checkbox"/> Liver disease<br><input type="checkbox"/> Measles<br><input type="checkbox"/> Migraines<br><input type="checkbox"/> Miscarriage<br><input type="checkbox"/> Mononucleosis<br><input type="checkbox"/> Multiple Sclerosis<br><input type="checkbox"/> Mumps<br><input type="checkbox"/> Osteoporosis<br><input type="checkbox"/> Pacemaker<br><input type="checkbox"/> Pneumonia<br><input type="checkbox"/> Polio<br><input type="checkbox"/> Prostate problem<br><input type="checkbox"/> Prosthesis<br><input type="checkbox"/> Psychiatric care<br><input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Rheumatic fever<br><input type="checkbox"/> Scarlet Fever<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Suicide attempt<br><input type="checkbox"/> Thyroid problem<br><input type="checkbox"/> Tonsillitis<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Tumors/growths<br><input type="checkbox"/> Typhoid fever<br><input type="checkbox"/> Ulcers<br><input type="checkbox"/> Viginal infections<br><input type="checkbox"/> Venereal disease<br><input type="checkbox"/> Whooping cough |
|---|--|--|---|

## GENERAL SYMPTOMS:

Place an "X" in boxes you have now or have had in the past.

- |  |  |  |   |
|--|--|--|---|
| <b>GENERAL</b><br><input type="checkbox"/> Back pain<br><input type="checkbox"/> Bruise easily<br><input type="checkbox"/> Chills<br><input type="checkbox"/> Dental problems<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Difficulty sleeping<br><input type="checkbox"/> Dizziness<br><input type="checkbox"/> Fainting<br><input type="checkbox"/> Fever<br><input type="checkbox"/> Forgetfulness<br><input type="checkbox"/> Headaches<br><input type="checkbox"/> Loss of sleep<br><input type="checkbox"/> Loss of weight<br><input type="checkbox"/> Neck pain<br><input type="checkbox"/> Nervousness<br><input type="checkbox"/> Numbness<br><input type="checkbox"/> Sweats<br><input type="checkbox"/> Tiredness<br><input type="checkbox"/> Weight gain | <b>GASTROINTESTINAL</b><br><input type="checkbox"/> Appetite poor<br><input type="checkbox"/> Bloating<br><input type="checkbox"/> Bowel changes<br><input type="checkbox"/> Constipation<br><input type="checkbox"/> Diarrhea<br><input type="checkbox"/> Excessive hunger<br><input type="checkbox"/> Excessive thirst<br><input type="checkbox"/> Gas<br><input type="checkbox"/> Hemorrhoids<br><input type="checkbox"/> Indigestion<br><input type="checkbox"/> Nausea<br><input type="checkbox"/> Rectal bleeding<br><input type="checkbox"/> Stomach Pain<br><input type="checkbox"/> Vomiting<br><input type="checkbox"/> Vomiting blood | <b>EYE, EAR, NOSE, THROAT</b><br><input type="checkbox"/> Bleeding gums<br><input type="checkbox"/> Blurred vision<br><input type="checkbox"/> Crossed eyes<br><input type="checkbox"/> Difficulty swallowing<br><input type="checkbox"/> Double vision<br><input type="checkbox"/> Earache<br><input type="checkbox"/> Ear discharge<br><input type="checkbox"/> Hay fever<br><input type="checkbox"/> Hoarseness<br><input type="checkbox"/> Hearing loss<br><input type="checkbox"/> Nosebleeds<br><input type="checkbox"/> Persistent cough<br><input type="checkbox"/> Ringing in ears<br><input type="checkbox"/> Sinus problems<br><input type="checkbox"/> Vision-flashes<br><input type="checkbox"/> Vision - halos | <b>MEN ONLY</b><br><input type="checkbox"/> Breast lump<br><input type="checkbox"/> Erection difficulties<br><input type="checkbox"/> Lump in testicles<br><input type="checkbox"/> Penis discharge<br><input type="checkbox"/> Sore on penis   |
| <b>GENITO-URINARY</b><br><input type="checkbox"/> Frequent urination<br><input type="checkbox"/> Blood in urine<br><input type="checkbox"/> Painful urination  | <b>CARDIOVASCULAR</b><br><input type="checkbox"/> Irregular heart beat<br><input type="checkbox"/> Low blood pressure<br><input type="checkbox"/> Poor circulation<br><input type="checkbox"/> Rapid heart beat<br><input type="checkbox"/> Swelling of the ankles<br><input type="checkbox"/> High blood pressure<br><input type="checkbox"/> Chest pain  | <b>SKIN</b><br><input type="checkbox"/> Itching<br><input type="checkbox"/> Change in moles<br><input type="checkbox"/> Rash<br><input type="checkbox"/> Scars<br><input type="checkbox"/> Bruise easily<br><input type="checkbox"/> Hives   | <b>WOMEN ONLY</b><br><input type="checkbox"/> Bleeding betw. periods<br><input type="checkbox"/> Breast lump<br><input type="checkbox"/> Extreme menstrual pain<br><input type="checkbox"/> Hot flashes<br><input type="checkbox"/> Nipples discharge<br><input type="checkbox"/> Painful intercourse<br><input type="checkbox"/> Vaginal discharge<br><input type="checkbox"/> Recent Pap smear<br><input type="checkbox"/> Abnormal pap smear<br><input type="checkbox"/> I am pregnant |

Date of last menstrual cycle \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Patient's Name (Printed) \_\_\_\_\_