Patient Questionnaire and Exam **Date:**

Name:	Date of Birth:
Occupation/Employer:	Highest level of Education:

Reason for Visit	
Hospitalizations	If you have ever been admitted to a hospital overnight, write the year, illness/operation. Do not include normal pregnancies/deliveries. Please start with most recent event.

Year	Illness/Operation	Year	Illness/Operation

Past Medical History/ Family History — Please check if you or any blood relative has/had any of the following conditions. Identify relationship of family member.

	Condition	Self	Relation		Condition	Self	Relation
1	Recent weight loss			17	Kidney / bladder problem		
2	Migraine headaches			18	Arthritis		
3	Epilepsy/Seizures			19	Osteoporosis		
4	Eye disease (other than glasses)			20	Cancer – Type:		
5	Hearing disorder			21	Neurological problems		
6	Recurrent nose bleeds/ sinus or throat infections			22	Skin condition / psoriasis / eczema		
7	Angina – Chest Pain			23	Bleeding disorder		
8	Heart attack			24	Blood transfusion		
9	High blood pressure			25	Anemia		
10	Stroke			26	Diabetes		
11	High cholesterol			27	Thyroid disease		
12	Heart valve disorder			28	Hair loss		
13	Lung disease			29	Mental illness		
14	Stomach ulcer			30	Depression		
15	Bowel problems			31	Alcohol or drug use / abuse		
16	Liver disease / Hepatitis			32	Major accident		

Medication History

List medication allergies:

List medications/dose/frequency:

MEDICATION	DOSE	FREQUENCY

Do you now or have you ever used:

	Y	N	Amount
Tobacco products Type:			
Alcohol			
Street drugs			
Coffee/Tea			

Health Maintenance
Please list date (year) of last:

Flu Vaccine		Tetanus Shot	
Hepatitis Vaccine		Pneumonia Vaccine	
TB Test		Cholesterol Test	
Stool Blood Test		Rectal Exam	
Dental Exam		Eye Exam	
MALES: Prostate Exam/PSA			

For Females Only

Date of last menstrual period:

Regular cycle:	Y	N
Spotting between periods	Y	N
Mood swings	Y	N
Birth control Type:	Y	N
Number of pregnancies		
Number of births		
Number of abortions		
Number of miscarriages		

Year and result of last:

Test	Date	Normal?	
PAP Test		Y	N
Breast Exam		Y	N
Mammo-gram		Y	N
Bone Density Scan		Y	N

Patient Signature:______________________________ Date:________________

Physician Signature:______________________________ Date:________________