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Medical Questionnaire

Name: _____ Date: _____

Referring Physician: _____

Primary Care Physician: _____

Are you? RIGHT Handed [] LEFT Handed [] BOTH []

What is the main problem for which you are being seen today?

How long have you had this problem? _____

Social History: (circle/fill in best answer)

Marital Status: Married Single Life Partner Separated Divorced Widowed

Tobacco Use: Never previously, but quit Current, packs per day _____

Alcohol Use: Do you currently drink alcohol? Yes or No
How much per day? _____ per week? _____

Drug Use: Never previously, but quit Type & Frequency _____

Caffeine Use: Never Cups per day _____

Occupation: Do you work outside of the home? Yes No Retired
What kind of work do you do? _____
Do you work shifts? Yes No Variable or Stable? _____

Exposure: Do you have excessive exposure at home or work to:
fumes dust solvents air-borne particles

Family History: (complete all that applies)

Table with 4 columns: Family Member, Age at Onset, Disease(s), If deceased, cause of death. Rows include Father, Mother, Brother(s), Sister(s), and Children (How many?).

Name: _____

Date: _____

Review of Systems: (please circle yes or no)

Constitutional Symptoms:

- Y N Good general health lately
- Y N Recent weight loss
- Y N Recent weight gain
- Y N Fever
- Y N Fatigue
- Y N Loss of appetite

Eyes:

- Y N Eye disease
- Y N Double vision
- Y N Wear corrective lenses
- Y N Visual loss
- Y N Blurred vision

Ears/Nose/Mouth/Throat:

- Y N Hearing Loss
- Y N Ringing in ears
- Y N Earaches
- Y N Swallowing problems
- Y N Chronic sinus problem

Cardiovascular:

- Y N Heart disease
- Y N Chest pain
- Y N Ankle swelling
- Y N Palpitations
- Y N Shortness of breath with walking
- Y N Shortness of breath while lying flat
- Y N Irregular heart beat
- Y N Calf pain with activity

Respiratory:

- Y N Frequent cough
- Y N Asthma
- Y N Wheezing

Gastrointestinal:

- Y N Diarrhea
- Y N Nausea
- Y N Vomiting
- Y N Constipation
- Y N Blood in stool
- Y N Abdominal pain
- Y N Heartburn
- Y N Ulcer

Genitourinary:

- Y N Frequent urination
- Y N Blood in urine
- Y N Incontinence
- Y N Kidney stones
- Y N Sexual difficulties
- Y N Male/testicle pain
- Y N Female/irregular periods
- Y N Urgency
- Y N Painful urination

Musculoskeletal:

- Y N Joint pain
- Y N Joint stiffness
- Y N Muscle cramps
- Y N Back pain

Integumentary (skin)

- Y N Rash
- Y N Itching
- Y N Change in skin color

Sleep Problems:

- Y N Do you sleep well?
- Y N Leg jerks at night?
- Y N Do you snore?
- Y N Are you fatigued on awakening?
- Y N Stop breathing at night?
- Y N Grind your teeth?

Previous Diagnosis of:

- Y N Sleep apnea
- Y N Restless leg syndrome
- Y N Narcolepsy

Psychiatric:

- Y N Memory loss
- Y N Confusion
- Y N Nervousness
- Y N Depression
- Y N Anxiety

Endocrine:

- Y N Thyroid disease
- Y N Diabetes
- Y N Excessive thirst
- Y N Heat intolerance
- Y N Cold intolerance

Neurologic:

- Y N Numbness
- Y N Tingling
- Y N Speech difficulties
- Y N Gait difficulties
- Y N One sided weakness
- Y N Tremor
- Y N Fainting
- Y N Swallowing difficulties