PATIENT QUESTIONNAIRE - ADULT

Name: _____ **DOB:** _____

Date: _____ **Referred from:** _____

Age: _____ **Height:** _____ **Weight (lbs):**_____ **Sex: Male / Female**

CHIEF COMPLAINT/HISTORY OF ILLNESS:

1. What is the reason for today's visit?_____
2. Have you sought legal advice for this problem? ❑ Yes ❑ No

PAST MEDICAL HISTORY (Please check any illnesses you have): ❑ None

Neurologic
- ❑ Alzheimer's disease
- ❑ Multiple sclerosis
- ❑ Bell's palsy
- ❑ Stroke/mini-stroke
- ❑ Parkinson's disease
- ❑ Seizures
- ❑ Migraines
- ❑ Chronic headaches

Eyes/Ear/Nose/Throat
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Hypothyroidism
- ❑ Hyperthyroidism
- ❑ Thyroid disease
- ❑ Laryngitis
- ❑ Recurrent tonsillitis
- ❑ Reflux
- ❑ Recurrent sinusitis
- ❑ Cholesteatoma
- ❑ Vasomotor rhinitis
- ❑ Otitis media/externa
- ❑ Allergic rhinitis
- ❑ Parotid swelling, recurrent
- ❑ Chronic cough
- ❑ Sleep apnea/snoring
- ❑ Otosclerosis
- ❑ Recurrent ear infections

Pulmonary/Cardiovascular
- ❑ High blood pressure
- ❑ Abnormal EKG/heart rhythm (_____)
- ❑ Heart aneurysm
- ❑ Carotid disease
- ❑ Coronary artery disease
- ❑ Asthma/Bronchitis
- ❑ Emphysema
- ❑ COPD
- ❑ Angina
- ❑ Heart disease
- ❑ Enlarged heart
- ❑ Peripheral vascular disease
- ❑ Valvular disease/murmur
  please specify _____
- ❑ Congestive heart failure (CHF)
- ❑ High/low cholesterol (circle one)
- ❑ Heart attack
- ❑ Pneumonia
- ❑ Chronic cough

Musculoskeletal
- ❑ Rheumatoid arthritis
- ❑ Joint disease
- ❑ Gout
- ❑ Neck/back disease
- ❑ Autoimmune disease
- ❑ Carpal tunnel syndrome
- ❑ Anemia
- ❑ Arthritis

Infectious Disease
- ❑ Sexually transmitted disease
  please specify _____
- ❑ Measles
- ❑ Mumps
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ AIDS
- ❑ Rubella
- ❑ Chicken pox
- ❑ Recurrent *Strep* infections

Endocrine/Psychiatric/Misc
- ❑ Diabetes- non-insulin dependent
- ❑ Diabetes – insulin-dependent
- ❑ Chronic fatigue
- ❑ Osteoporosis
- ❑ Schizophrenia
- ❑ Anxiety
- ❑ Attention Deficit Disorder
- ❑ Panic attacks
- ❑ Bipolar disorder
- ❑ Bleeding disorder
- ❑ Depression

Gastrointestinal/Genitourinary
- ❑ BPH
- ❑ Hiatal hernia
- ❑ Gall bladder disease
- ❑ Irritable bowel syndrome
- ❑ Kidney disease/stones
- ❑ Hepatitis (please specify _____)
- ❑ Peptic ulcer disease

❑ Cancer (including skin): _____

❑ Skin condition (i.e., rosacea, psoriasis, eczema): _____

❑ Other: _____

PAST SURGICAL HISTORY (Please check any surgeries you have had): ❑ None

- ❑ Heart bypass/valve
- ❑ Coronary angioplasty
- ❑ Carotid artery surgery
- ❑ Vascular bypass
- ❑ Mastectomy
- ❑ Heart transplant
- ❑ Adenoidectomy
- ❑ Ear surgery
- ❑ Facial fracture repair
- ❑ Pacemaker placement
- ❑ Plastic surgery
- ❑ Gall bladder
- ❑ Lung surgery
- ❑ Joint replacement
- ❑ Back surgery
- ❑ Brain surgery
- ❑ Liver transplant
- ❑ Breast augmentation/reduct
- ❑ Facelift
- ❑ Hair transplant
- ❑ Rhinoplasty
- ❑ Thyroidectomy
- ❑ Prostate removal
- ❑ Colon removal
- ❑ Appendix removal
- ❑ Sinus surgery
- ❑ Tonsillectomy
- ❑ Kidney transplant
- ❑ Cataract surgery
- ❑ LASIK
- ❑ Hiatal hernia repair
- ❑ Septoplasty
- ❑ Turbinate reduction
- ❑ Hysterectomy
- ❑ Liposuction
- ❑ Sinus surgery
- ❑ Ulcer surgery

Others:_____

Describe any complications you had related to surgery: _____

Describe any complications you had related to anesthesia: ❑ None ❑ Nausea ❑ Vomiting _____

ALLERGIES (List medications/foods you are allergic to and what happens when you take them): ❑ None

a) Medication_____Reaction_____

b) Foods_____Reaction_____
c) Non Drug Allergies_____
d) Do you have a history of anaphylaxis? ❑ Yes ❑ No
e) Do you have an allergy to latex? ❑ Yes ❑ No
f) Do you have a history of a transfusion reaction? ❑ Yes ❑ No

FAMILY HISTORY (Check all illnesses that run in your family): ❑ None

❑ Hearing loss	❑ Alcoholism	❑ Heart attack	❑ Migraines_____
❑ High blood pressure	❑ Psychiatric illness	❑ Cancer	❑ Allergies_____
❑ Sickle cell anemia	❑ Bleeding problems	❑ Diabetes	❑ Others_____
❑ Poor Circulation	❑ Anesthesia reaction	❑ Stroke	_____
❑ Alzheimer's Disease	❑ Anxiety	❑ Arthritis	❑ Asthma
❑ Breast Cancer	❑ Other cancer (please specify: _____)		
❑ Colon polyps/cancer	❑ COPD/emphysema	❑ Coronary artery disease	
❑ Gallbladder disease	❑ High cholesterol	❑ Melanoma	❑ Mental illness
❑ Osteoporosis	❑ Parkinson's disease	❑ Thyroid disease/cancer	
❑ Do not know family history			

SOCIAL HISTORY:

Occupation /School :_____Marital status: ❑Married ❑Single ❑Divorced ❑ Widowed
How many children do you have?_____
Have you ever smoked? ❑ Yes ❑ No (❑ cigarettes, ❑ cigar, ❑ pipe) Do you chew tobacco? Yes No
How much, and for how long have you smoked? _____Packs per day for_____years. Stopped when:_____
How many alcoholic beverages do you drink each day?_____Stopped when:_____
List any recreational drugs you currently use:_____
Do you have any drug addictions?_____
How many caffeinated beverages do you consume in a day? _____
What do you do for exercise? _____ How often? _____
Do you have an advance directive? ❑ Yes ❑ No

REVIEW OF SYSTEMS (Check all symptoms you have had either now or in the past):

CONSTITUTIONAL

❑ Weight loss_____pounds in the past ____weeks ❑ Fever, chills ❑ Night sweats ❑ **None**
❑ Fatigue ❑ Loss of appetite

EYES:

❑ Wears glasses	❑ Blurring of vision	❑ Redness	❑ Other:
❑ Wears contacts	❑ Swelling	❑ Itchy eyes	_____
❑ Blindness	❑ Dryness of eyes	❑ Double vision	
❑ Watery eyes	❑ Eye pain	❑ Discharge	❑ **None**

ENT:

❑ Allergies	❑ Ear pain	❑ Hearing loss	❑ Nosebleeds	❑ Snoring
❑ Bleeding gums	❑ Facial pain	❑ Heartburn	❑ Nose pain	❑ Sore throat
❑ Decreased/lost smell	❑ Gum disease	❑ Hoarseness	❑ Septal perforation	❑ Sores on lips/gums
❑ Dentures	❑ Facial pain	❑ Mouth sores	❑ Teeth problems	❑ Voice changes
❑ Difficulty swallowing	❑ Gum disease	❑ Nasal congestion	❑ Postnasal drip	❑ Throat pain
❑ Dizziness/vertigo	❑ Headaches	❑ Nasal discharge	❑ Rhinorrhea	❑ Bad breath/taste
❑ Ear drainage	❑ Hearing aids	❑ Nasal obstruction	❑ Ringing in ears/tinnitus	

❑ **None**
❑ Other _____

CARDIOVASCULAR:

❑ Shortness of breath (at rest) ❑ Palpitations
❑ Shortness of breath (exertion) ❑ Chest pain/pressure
Other _____ ❑ **None**

Name: _____

PULMONARY/RESPIRATORY

❑ Cough ❑ Coughing blood (hemoptysis) ❑ Shortness of breath
❑ **None** ❑ Other: _____

GASTROINTESTINAL:

❑ Abdominal pain ❑ Change in bowel habits ❑ Nausea and vomiting ❑ Diarrhea
❑ Vomiting blood (hematemsis) ❑ Use of antacids ❑ Blood in stool
❑ **None** ❑ Other: _____

GENITOURINARY:

❑ Blood in urine (hematuria) ❑ Hesitancy ❑ Nocturia ❑ Wets bed (enuresis)
❑ **None** ❑ Other: _____

MUSCULOSKELETAL:

❑ Back pain ❑ Neck pain ❑ Weakness
❑ **None** ❑ Other: _____

SKIN:

❑ Acne ❑ Itching ❑ Birth marks ❑ Loss of hair ❑ Change in mole
❑ Skin rashes ❑ Dryness ❑ **None** ❑
Other:_____

NEUROLOGICAL:

❑ Memory loss ❑ Paralysis of arm or leg ❑ Speech difficulty ❑ Paresthesia
❑ Syncope ❑ Head trauma ❑ Near syncope ❑ Local weakness
❑ Numbness ❑ **None** ❑ Other:
_____

PSYCHIATRIC:

❑ Disturbing thoughts/feelings ❑ Suicidal thoughts ❑ Hallucinations
❑ **None** ❑ Other: _____

ENDOCRINE

❑ Heat or cold intolerance ❑ Thyroid nodule ❑ Hair loss ❑ Increased thirst
❑ **None** ❑ Other: _____

HEMATOLOGY/LYMPHATIC: ❑ Abnormal bleeding ❑ Easy bruising ❑ **None**
❑ Are you currently being anticoagulated? ❑ Yes ❑ No ❑ Enlarged lymph nodes

ALLERGY/IMMUNOLOGY

❑ Itchy eyes ❑ Red eyes ❑ Sneezing ❑ Hayfever
❑ Itchy nose ❑ Swollen eyes ❑ Urticaria ❑ Eye discharge
❑ Rashes ❑ **None** ❑ Other:
_____

DO YOU HAVE ANY IMPLANTABLE DEVICES? If so, what and where? _____

MEDICATIONS (List all your current medications and the dose you take): ❑ None (please use back if needed)

Medication_____Dose_____
Medication_____Dose_____
Medication_____Dose_____

Do you take Aspirin or Ibuprofen? ❑ Yes ❑ No
Do you take Warfarin (Coumadin)/Plavix? ❑ Yes ❑ No Have you taken steroids within the past year? ❑ Yes ❑ No

Thank you for your cooperation

I have personally reviewed this history and review of systems

_____ _____
Attending Physician Signature Date