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INITIAL HISTORY QUESTIONNAIRE

DATE:_____

NAME:_____ **DATE OF VISIT**:_____

We ask that you take time to complete this questionnaire to the best of your knowledge. This questionnaire will allow the doctor to get to know more about you, your medical condition, your family and your life experiences. **The questionnaire is confidential and will be kept as part of your medical records.**

REFERRING PHYSICIAN INFORMATION:

NAME:_____

ADDRESS:_____

TELEPHONE NUMBER:_____

SPECIALTY:_____

If you were not referred by a physician, who referred you?_____

Is your appointment associated with any legal or potential legal activity?_____

If so, please elaborate:_____

HISTORY OF PRESENT ILLNESS:

Briefly describe the reason for your visit:_____

_____

_____

1. What symptoms are you experiencing if any?_____

_____

2. How severe is the problem?_____

_____

3. How long have your had the problem?_____

_____

4. If yes, did you obtain treatment?_____

5. Have you experienced similar symptoms or had a similar problem in the past?_____

6. Does anything help make the problem go away?_____

   If so, what?_____

7. With whom and for how long?_____

REVIEW OF SYSTEMS

Please circle and provide a brief detail below for the medical conditions below which apply to you whether past or present.

CONSTITUTIONAL
Weight loss or gain
Change in appetite
Altered taste or smell
Excessive sleepiness
Unable to sleep
Fatigue
Fever

EYES
Blurred vision
Double vision
Glaucoma
Cataracts

RESPIRATORY
Emphysema
Chronic cough
Tuberculosis
Difficulty breathing

CARDIO-VASCULAR
Chest pain/pressure
Angina
Leg Swelling
High blood pressure
Low blood pressure
Shortness of breath
Fainting

EAR, NOSE, MOUTH, THROAT
Hearing loss or ringing in ears
Dizziness
Nose bleeds/discharge
Trouble breathing through nose
Sinus disease
Mouth sores
Sore throat
Trouble swallowing

GASTROINTESTINAL
Diarrhea
Rectal bleeding
Hepatitis
Abdominal pain
Vomiting
Constipation

INTEGUMENTARY
Skin rash
Hives
Itching

HEMO-LYMPHATIC
Blood disorder
Enlarged lymph nodes

ENDOCRINE
Diabetes
Thyroid disease
Breast disease
Male/Female Endocrine problems

GENITOURINARY
Painful urination
Blood in urine
Frequent urination
Urinary urgency
Urinary incontinence
Impotence
Sexual dysfunction
Venereal disease
Vaginal disease
Changes in libido
Sexual concerns

PSYCHOLOGICAL
Depression
Anxiety
Trouble concentrating
Confusion
Fears
Self-destructive behavior
Racing thoughts
Abnormal thoughts

NEUROLOGIAL
Headache
Seizures
Loss of consciousness
Memory loss
Weakness/Numbness
Tingling
Trouble walking
Trouble with balance
Vertigo

MUSCULOSKELETAL
Low back pain
Neck pain
Joint pain
Joint Swelling
Muscle spasms

ALLERGY/IMM
Allergies-Food
Allergies-Drug (specify below)

AIDS/HIV

ALLERGIES (Specify):_____

RECREATIONAL DRUG USE (Specify):_____

Please list ALL CURRENT MEDICATIONS you are taking (including over the counter drugs, vitamins, and supplements) with dosage and times at which they are taken:

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

PAST MEDICAL HISTORY

Please indicate all medical and/or psychiatric hospitalizations you have had in the past, with approximate dates and reason for admission:

_____

_____

Please list ALL CURRENT MEDICAL PROBLEMS, as well as major illnesses you have had in the past with approximate dates:

_____

_____

FAMILY HISTORY

Please list all medical and psychological problems and current ages of the following family members. If they are deceased, please list cause and approximate age of death.

GRANDPARENTS: 1._____

2._____

3._____

4._____

MOTHER:_____

FATHER:_____

BROTHERS: (List name, age, occupation, brief history)_____

_____

_____

SISTERS: (List name, age, occupation, brief history)_____

_____

_____

CHILDREN: (List name, age, occupation, brief history)_____

_____

_____

SOCIAL HISTORY

Please circle your highest level of education:

Grade School High School College/Vocational School Graduate

Where do you work? (If retired or unemployed, list most recent place of employment and last date of work)

_____

_____

What is/was your position there?_____

Please Circle One

Are you: Single Married Divorced Separated Widowed

Have you been married more than once?_____

Spouse's occupation (if applicable):_____

Current living arrangements:_____

Hobbies:_____

Do you smoke? Yes No If you smoked and quit, date you quit:_____

Do you drink alcohol? Yes No If you drank and quit, date you quit:_____

If you consume alcohol, approximately how many drinks per week?_____

Have you ever had a problem with alcohol and/or drugs?_____

Do you exercise regularly?_____

Current Weight:_____ Current Height:_____

Pharmacy where you fill your prescriptions, location, and telephone number:_____

_____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM