

Patient Questionnaire



Patient Name _____

Today's Date: _____

Date of Birth: _____

Sex: Male Female

Height: _____ Weight: _____

Marital Status: Single Married Divorced Widowed Separated

History of Past Illness:

Have you had any of the following? (Please check YES or NO)

Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Tuberculosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Heart Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Stroke	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Venereal Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO			
Cancer	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Rheumatic Fever	<input type="checkbox"/> YES	<input type="checkbox"/> NO			

Have you had any serious illness?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you ever been hospitalized or been under medical care very long?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, for what reason?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you had any surgery?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, please list: _____		
Have you had any broken bones?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you had any concussions or head injuries?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you ever been knocked unconscious?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

GENERAL			CARDIOVASCULAR		
Recent weight change?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Chest pain or angina pectoris	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you been in good general health most of your life?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Shortness of breath	<input type="checkbox"/> YES	<input type="checkbox"/> NO
EYES-EARS-NOSE-THROAT			Heart trouble or heart attacks	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Eye disease or injury	<input type="checkbox"/> YES	<input type="checkbox"/> NO	High blood pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you wear glasses / contacts?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Swelling of hands, feet, or ankles	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have double vision?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Heart murmur	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Ear disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO	RESPIRATORY		
Impaired hearing	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Do you have a persistent cough?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Nosebleeds	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Do you smoke?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Chronic sinus trouble	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Do you have an URI (cold) now?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Sneezing or runny nose	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Tuberculosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you wear dentures?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Asthma or wheezing	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Dizziness or transient episodes of unconsciousness	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Difficulty breathing or shortness of breath	<input type="checkbox"/> YES	<input type="checkbox"/> NO
SKIN			Pleurisy or pneumonia	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Jaundice	<input type="checkbox"/> YES	<input type="checkbox"/> NO			
Hive, eczema, or rash	<input type="checkbox"/> YES	<input type="checkbox"/> NO			
Frequent infection or boil	<input type="checkbox"/> YES	<input type="checkbox"/> NO			
Abnormal pigmentation	<input type="checkbox"/> YES	<input type="checkbox"/> NO			

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(Please check YES or NO)

GASTROINTESTINAL			NEUROLOGICAL						
Peptic ulcer (stomach or duodenal)	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Numbness	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Vomiting blood or food	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Headache	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Gallbladder disease	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Tremor	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Liver trouble	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Seizure	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Hepatitis	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Blackout	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Painful bowel movements	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Stroke	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Bleeding with bowel movement	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO					
Black stools	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	PSYCHIATRIC				
Recent change in bowel habits	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Have you ever had psychiatric care?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Hemorrhoids	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Are you often anxious?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Frequent diarrhea	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Are you depressed?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Heartburn or indigestion	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Do you have difficulty sleeping?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
GENITOURINARY			HEMATOLOGIC						
Loss of urine	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Are you slow to heal after cuts?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Frequent urination	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Blood disease	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Night time urination	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Anemia	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Burning or painful urination	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Have you had abnormal bruising or bleeding?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Blood in urine	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO					
Kidney trouble	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	ALLERGIC				
Kidney stones	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Any allergies, including medications	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
					If yes, please list:				
LOCOMOTOR-MUSCULASKELETAL			ENDOCRINE						
Weakness of muscles or joints	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Do you have diabetes?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Any difficulty walking	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Are you always tired?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Any pain in calves or buttocks with walking relieved by rests?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	Do you have thyroid problems?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Neck pain	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO					
Lower extremity pain	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO					
Low back pain	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO					