Patient Survey

(Please Print Clearly)

Date:_____

Name:_____ Date of Birth: _____/_____/_____

Medical History

Please provide us with an overview of issues that have been addressed by a medical professional.

_____
_____
_____
_____
_____

Are there any issues that you would like to discuss today that have not be addressed fully by another medical professional?

_____
_____
_____

Please list any surgeries that you have had and when:

_____
_____
_____

Were you ever hospitalized? Why and When?

_____
_____
_____

List all prescription and non-prescription medications, dose, frequency, how long and who prescribes them?

_____
_____
_____
_____
_____
_____

Please go onto the back page if you need more space

Allergies

List allergies and sensitivities to medications as well as the reactions:

_____
_____
_____
_____
_____

Do you have food allergies? List: _____

Reaction to insect bites? List: _____

Allergic to animals? List:_____

Seasonal allergies? List: _____

Other allergies? List: _____

Social History

What is your occupation? _____

How many years? _____

Marital Status: Single Married Divorced Widowed

What do you consider your stress level is? Low Medium High

Travel outside the U.S. within the past three years? Yes No

Where and when? _____

On a scale of 1-5 (1 representing low use, 5 representing habitual use; please rate below)

Current		Past			
Alcohol use	_____	Alcohol use	_____	Total years of alcohol use	_____
Caffeine use	_____	Caffeine use	_____	Total years of caffeine use	_____
Tobacco use	_____	Tobacco use	_____	Total years of tobacco use	_____
Illegal Drug use	_____	Illegal Drug use	_____	Type & Total yrs of use	
				_____	
Unsafe Sex	_____	Unsafe Sex	_____	_____	
Regular Exercise	_____	Regular Exercise	_____	Type & Total yrs of Exercise	
				_____	
				_____	

Preventative Care

Please list the date of your most recent; if unknown please circle unknown:

Complete physical _____ Unknown
Tuberculosis Test _____ Unknown
Tetanus Immunization _____ Unknown
Pneumonia Immunization _____ Unknown
Influenza Immunization _____ Unknown
Measles Immunization _____ Unknown
Hepatitis A and or B Immunization _____ Unknown
Colonoscopy _____ Unknown
Dental Cleaning _____ Unknown

Family History

Circle Living or	Deceased	Please list any inherited diseases, chronic illness or cause of death
LIVING	DECEASED	FATHER
LIVING	DECEASED	MOTHER
LIVING	DECEASED	PATERNAL GRANDFATHER
LIVING	DECEASED	PATERNAL GRANDMOTHER
LIVING	DECEASED	MATERNAL GRANDFATHER
LIVING	DECEASED	MATERNAL GRANDMOTHER
LIVING	DECEASED	BROTHERS
LIVING	DECEASED	SISTERS
LIVING	DECEASED	SONS
LIVING	DECEASED	DAUGHTERS

Have any of your family members had any of the following diseases? Please circle:

HEART DISEASE	HIGH BLOOD PRESSURE	MENTAL RETARDATION	ALCOHOL/DRUG ABUSE
HIGH CHOLESTEROL	HEPATITIS	SEIZURES	ASTHMA
EMPHYSEMA	MIGRAINE HEADACHES	SICKLE CELL	TUBERCULOSIS
DIABETES	SUICIDE	SUICIDE	COLON POLYPS
MENTAL ILLNESS	BLINDNESS	ANXIETY	CANCER
ANEMIA	STROKE	ALLERGIES	KIDNEY DISEASE
THYROID DISEASE	DEAFNESS	DEPRESSION	LUNG DISEASE
ADHD	SUDDEN DEATH		

Please circle any of the following if they apply:

CHEST PAIN	KIDNEY STONES	DIZZINESS
CHRONIC SINUS INFECTIONS	PALPATATIONS	FAINTING
DIGESTIVE PROBLEMS	URINARY PROBLEMS	CHRONIC FEVER
WHEEZING/ASTHMA	SEIZURES	CHRONIC DIARRHEA
SKIN PROBLEMS	NOSE BLEEDS	COUGH
HEADACHES	SKIN MOLES	MEMORY
FREQUENT FALLS	VISION	HEARING PROBLEMS
VOMITING BLOOD	NIGHT SWEATS	COORDINATION
ARTHRITIS/JOINT PAIN	PELVIC INFLAMMATION	TEETH/GUM PROBLEMS
TROUBLE WALKING	EXCESSIVE THIRST	FEET/LEG SWELLING
MENSTRUAL/VAGINAL	TESTICULAR PROBLEMS	HEMORRHOIDS
SEXUAL FUNCTION	BACK/NECK INJURIES	SWALLOWING/THROAT
BLOOD IN URINE	WEIGHT LOSS/GAIN	OBESITY
ANOREXIA/BULIMIA	STD ISSUES/CONCERNS	APPETITE
ABDOMINAL PAIN	COUGHING BLOOD	FATIGUE
VOMITING	BREATHING	CONSTIPATION
BLOOD IN STOOLS	ATTENTION DEFICIT DISORDER	TOURETTE'S SYNDROME
STUTTERING	CHRONIC BLADDER INFECTIONS	GERD

Are you currently experiencing any of the following? Please circle all the apply:

Loss of interest in things you used to enjoy	thought of death/suicide
Chronic sadness	feelings of worthlessness, guilt
Problems concentrating/decision making	loss of energy/exhaustion
Restlessness, inability to sit still	changes in appetite
Hopelessness	other: please list
	_____

FOR FEMALES ONLY

First Day of Last Menstrual Period: _____/_____/_____

Length of period_____days; typical interval between periods_____days

Form of Birth Control:_____

Date of last Pap Smear: ____/_____/_____Provider Name:_____

Date of last Mammogram: ____/_____/_____ Benign Exam? Yes or No

Menopause? Yes or No

Recent pregnancy Yes or No; Miscarriages Yes or No; Live Births Yes or No; Terminations Yes or No