Medical Questionnaire

Name: ___________________________ **Date of Birth**: ___/___/___**Age**: ________

CHIEF COMPLAINT(s) [main reason(s) for appointment] ______________________
____
____

Were Lab or X-rays done: YES NO If yes where? _________________________

Do you have any **ALLERGIES TO MEDICINE**? ______________________________

History of Present Illness: (Please answer the following questions NA if not applicable)
Location of Problem: ____
How does the problem rate? 1 2 3 4 5 6 7 8 9 10 (worst)
When did you first notice the problem? ____
Does anything help or make problem worse (lying on side, standing, moving, etc.)?
____
How long does the problem last? __________________________________
Is anything occurring at the same time (rash, headache, nausea, etc.)? _________________
Is the problem constant or variable? _______________ What does it feel like? ___________
Does the problem interfere with your normal function? _____________________________
If yes, please explain: ____

Past Medical & Family History: (Please check all that apply to you or your family)

	Self	Family		Self	Family		Self	Family
Alcoholism			Diabetes			High Blood Pressure		
Arthritis			Depression			Kidney Failure		
Asthma			Emphysema			Kidney Stones		
Blood Disorders			Glaucoma			Tuberculosis		
Cancer-Type?			Heart Disease			Other		

Please list all MEDICATIONS: (**include over the counter & HERBAL REMEDIES**)

Medications/Supplements	Dosage	Medications/Supplements	Dosage

Please list any OPERATIONS and Dates:

FOR FEMALES ONLY:

Date of Last Menstrual Period ___/____/___ # Pregnancies _______ #Births _______
#Miscarriages_________ #Abortions ________ # Living Children__________
Date of Last PAP ___/_____/_____ Any History of abnormal PAP? YES NO
When? _______________________ Date of Last Mammogram? _______________

Are you currently: Single Married Divorced Widow(er) How Long? ____________
Have you been married more than once? YES NO How many times? ______________
If you have children: How Many? __________ What are their gender(s) and age(s)?
____
____
Are you currently: Employed Retired Disability Occupation? _____________________
Do you smoke cigarettes? YES NO If so, how much? _______pack(s) per day. Quit When? ___________
Do you use any other tobacco products (cigars, chewing tobacco, snuff, etc.)? Type: __________________
Do you use recreational drugs? YES NO Type: __________________ Frequency: _________________
Do you drink alcohol? NEVER OCCASIONAL MODERATE HEAVY Quit When? ____________
Do you drink coffee? YES NO Cups per day: ________ Sodas? YES NO Type___________ Cans/day _______
Do you exercise regularly? YES NO Describe: ____
Is your sleep restful? YES NO Hours per night: ___________________
Are you currently seeing any health care professionals (Naturopath, Medical Doctor, Chiropractor, etc.)? __________________

Are there ANY other problems that have not been mentioned? ___________________________________

REVIEW OF SYMPTOMS

Constitutional Symptoms			**Gastrointesinal**			**Genitourinary**		
Fever	Y	N	Abdominal Pain	Y	N	Urine Retention	Y	N
Chills	Y	N	Nausea/Vomiting	Y	N	Painful Urination	Y	N
Headache	Y	N	Indigestion/Heartburn	Y	N	Urinary Frequency	Y	N
Other	Y	N	Diarrhea	Y	N	Other	Y	N
Eyes			Other	Y	N	**Respiratory**		
Blurred Vision	Y	N	**Cardiovascular**			Wheezing	Y	N
Double Vision	Y	N	Chest Pain	Y	N	Frequent Cough	Y	N
Pain	Y	N	Varicose Veins	Y	N	Shortness of Breath	Y	N
Other	Y	N	High Blood Pressure	Y	N	Other	Y	N
Allergic/Immunologic			Other	Y	N	**Hematologic/Lymphatic**		
Hay Fever	Y	N	**Integumentary**			Swollen Glands	Y	N
Drug Allergies	Y	N	Skin Rash	Y	N	Blood Clotting Disorder	Y	N
Other	Y	N	Boils	Y	N	Other	Y	N
Neurological			Persistent Itch	Y	N	**Psychologic**		
Tremors	Y	N	Other	Y	N	Are you generally satisfied		
Dizzy Spells	Y	N	**Musculoskeletal**			with your life?	Y	N
Numbness/Tingling	Y	N	Joint Pain	Y	N	Do you feel severly depressed?	Y	N
Other	Y	N	Neck Pain	Y	N	Have you considered suicide?	Y	N
Endocrine			Back Pain	Y	N			
Excessive Thirst	Y	N	Other	Y	N			
Too hot/cold (circle)	Y	N	**Ear/Nose/Throat/Mouth**			**# of Yes Answers** **Level of Service**		
Tired/Sluggish	Y	N	Ear Infection	Y	N	0-1 1 or 2		

For Doctors Use Only

Assessment:

Plan:

Physician: