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PATIENT HISTORY QUESTIONNAIRE

Please complete and bring this form with you to your first appointment

Name: ______________________________ Date of Visit: ____________
Date of Birth: ________________ Referring Health Care Provider: ______________

Your contact information:

Home phone: ____________________________ Cell phone: ______________
Email address: ____

History of Present Illness (HPI):

Purpose of today's visit: ______________________________________
____

Location: ____________________
(Where on the body symptom occurs)

Duration: ______________________
(How long have you had symptom? How long does it last?)

Severity: ____________________
(Severe, worse, slightly. Pain scale 1-10)

Quality: ______________________
(Character of symptom…burning, gnawing, stabbing)

Timing: ____________________
(When symptoms occur)

Context: ______________________
(Situation associated with symptom)

Modifying Factors: ______________________________________
(Things to make symptoms better or worse)

Associated Signs/Symptoms: ______________________________
(Other things that happen when this symptom occurs)

PAST MEDICAL HISTORY: **Please place a mark beside those that apply to you:**

- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Cancer
- ❑ Respiratory Problems
- ❑ Stroke
- ❑ Heart Trouble
- ❑ Bleeding Problems
- ❑ Increased Cholesterol
- ❑ Asthma
- ❑ Emphysema
- ❑ COPD
- ❑ Stomach Ulcers
- ❑ Anemia
- ❑ Seizures
- ❑ Thyroid Problems
- ❑ Blood Clots
- ❑ HIV/AIDS
- ❑ Intestinal Bleeding
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Pnemonia/TB
- ❑ Arthritis
- ❑ Gout

LUNG HISTORY: **Please place a mark beside those that apply to you**

Pulmonary Symptoms:

❑ Shortness of Breath ❑ Non-productive Cough ❑ Wheezing
❑ Productive Cough ❑ Bloody Sputum

Use of Pulmonary Treatments:

❑ Inhalers ❑ Steroids ❑ Immunosuppressive Drugs
❑ Nebulizers ❑ Home oxygen

Exposures:

❑ Asbestos ❑ Sick contacts ❑ Tuberculosis
❑ Travel Outside of US

History of:

❑ Lung mass ❑ Lung nodule ❑ Lung scar on x-ray

PAST SURGICAL HISTORY: **List all the surgeries you have had in the past (most recent first)**

Year: ________________ Surgery: ______________________ Hospital: __________________
Year: ________________ Surgery: ______________________ Hospital: __________________
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Year: ________________ Surgery: ______________________ Hospital: __________________
Year: ________________ Surgery: ______________________ Hospital: __________________
Year: ________________ Surgery: ______________________ Hospital: __________________

PAST FAMILY HISTORY: **Please list any medical problems in your relatives**

Father: ____
Mother: ____
Brothers/Sisters: ____
Others: ____

PAST SOCIAL HISTORY: **Please place a mark beside those that apply to you**

Marital Status:

❑ Single ❑ Separated ❑ Widowed
❑ Married ❑ Divorced

Occupation __________________________ **Other** ________________________________

Tobacco Use:

❑ Yes ❑ No ❑ Never ❑ Quit

Smoker/How Much? _______________________ Quit/When? ________________________
Duration in years: ____

Alcohol Use:

❑ Yes ❑ No ❑ Never

How Often?

❑ Rarely ❑ Moderate ❑ Daily

How Much? ____

Drug Use:

❑ Yes ❑ No ❑ Never

Type and frequency: ____

Psychiatric/Behavioral Issues: ____

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REVIEW OF SYMPTOMS: **Please place a mark beside those that apply to you**

Constitutional:
❑ Fever ❑ Weight Loss ❑ Anorexia ❑ Visual changes

Ear, Nose and Throat:
❑ Hearing loss ❑ Sinus drainage ❑ Sore Throat
❑ Ear ache ❑ Frequent Nose Bleeds

Cardiac:
❑ Chest Pain ❑ Pain in legs while walking (Claudication)
❑ Palpitations ❑ Dizziness
❑ Shortness of Breath on Exertion (DOE) ❑ Fainting (Syncope)
❑ Shortness of Breath at Night (PND) ❑ Transient Visual Loss (Amaurosis Fugax)

Gastroentestinal:
❑ Abdominal pain ❑ Diarrhea/Constipation
❑ Gastroesophageal Reflux Disease (GERD) ❑ Vomiting blood (Melena)
❑ Inability to swallow (Dysphagia) ❑ Bright red blood per rectum (BRBPR)

Urological:
❑ Painful urination (Dysuria) ❑ Incontinence
❑ Urgency of urination ❑ Renal Insufficiency

Musculoskeletal:
❑ Muscle Aches ❑ Cramps ❑ Weakness

Respiratory:
❑ Shortness of Breath (SOB) ❑ Wheeze
❑ Cough

Skin:
❑ Rash ❑ Itching ❑ Breast Mass
❑ Skin Ulcers ❑ Breast Pain

Neurological:
❑ Stroke ❑ Weakness ❑ Numbness
❑ Mental Status Change ❑ Transient Ischemic Attack (TIA)

Psychiatric:
❑ Mood swings ❑ Depression ❑ Anxiety/Panic ❑ Seizures

Endocrine:
❑ Hypothyroid ❑ Hyperthyroid ❑ Diabetes ❑ On Steroids

Hematologic:
❑ Anemia ❑ Enlarged lymph nodes
❑ Easy Bruising ❑ Bleeding tendency (Bleeding diathesis)

Immunologic: Allergies: ______________________________
Frequent Illnesses: ______________________________

CARDIOVASCULAR HISTORY:
Heart Attack: ______________________________
Angioplasty or Stent: ______________________________
Coronary Artery Bypass Surgery: ______________________________
Congestive Heart Failure: ______________________________
Atrial Fibrillation: ______________________________
Pacemaker/Defibrillator: ______________________________
Ablation Procedure: ______________________________
Valve Problems/Surgery: ______________________________

Heart Murmur: ____
Leg artery blockage/amputation: ______________________________________
Kidney artery blockage: ____
Stroke, mini-stroke or TIA: ____
Carotid Artery Surgery: ____
Enlarged aorta/aneurysm: ____
Other: ____

COMMUNICATION:

What language do you speak? ______________________ Would you like an interpreter? ____

CURRENT MEDICATIONS:

Please list all medications, vitamins, and supplements that you take below. Please make sure your list is accurate and up to date. If you have an up to date and readable copy of your medication list, you may bring that with you instead of filling out this form:

Name of Medication **Dose** **How often do you take it?**

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____
11. ____
12. ____
13. ____
14. ____
15. ____
16. ____
17. ____
18. ____

ALLERGIES:

Name of Medication **What happened?** **When?**

1. ____
2. ____
3. ____
4. ____
5. ____

Patient Statement:

To the best of my knowledge, the above information is accurate and complete.

Signed _________________________________ Date ________________