PATIENT QUESTIONNAIRE

Name:____ **Date:**___________________

How did you hear about our office?____

What other doctors do you see?____

Reason for your visit today?____

Have you had an EKG?_____Y_____N. If yes, where and how long ago?___________________________

Please list all medications, including dosage & frequency:

1._________________________________ 5.__________________________________
2._________________________________ 6.__________________________________
3._________________________________ 7.__________________________________
4._________________________________ 8.__________________________________

Do you have any allergies to latex, adhesives, or medications? _____Y _____N If yes, please list allergies:_______
____

Have you been diagnosed with any medical conditions?_______________________________________

Is your father living?____Y ____N. If yes, what is his state of health?______________________________
If no, age of death____________ and cause of death______________________________________
Is your mother living?____Y _____N. If yes, what is her state of health?_____________________________
If no, age of death____________ and cause of death______________________________________
Do you have any brothers?_____Y _____N. If yes, how many_________ and what is his state of health?__________
Do you have any sisters?_____Y _____N. If yes, how many __________ and what is her state of health?__________
Do you have any children?____Y _____N. If yes, how many_____ and what is his/her state of health?___________
Do you ever drink alcohol?____Y ____N ____quit. If yes, is it occasional_______ moderate________ heavy_______
Do you drink caffeine?___Y ______N. If yes, is it coffee____ tea____ soda_____. Servings per day?______________
Do you ever use tobacco?____Y ____N ____quit. If yes, how often __________, how long _________ and what type __________. If you quit, what was your age_____ and what year_________ did you quit.
What are your exercise habits? inactive____ light____ moderate____ heavy____
Frequency & duration of exercise___________________________
What are your nutrition habits? well balanced diet____ special diet____ poor balanced diet____ vegetarian_____.
Do you take any dietary supplements or multivitamins?______Y_____N
What is your primary occupation?____
List any major surgical procedures:____
____
List any other past medical history not listed above:_______________________________________
____