

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.) _____ M F DOB: _____ Age: _____

Current Primary Care Doctor: _____ Date of last physical exam: _____

Referring Doctor: _____ Date of last laboratory studies: _____

Reason for visit: _____

PAST MEDICAL HISTORY / REVIEW OF SYMPTOMS

Have you ever been diagnosed with or are you currently under care for:				<i>(please mark all lines, diagnosed and year.)</i>			
DISEASE/SYMP TOM	YES	NO	YRS.	DISEASE/SYMP TOM	YES	NO	YRS.
1. High Blood Pressure	_____	_____	_____	30. Rheumatoid arthritis	_____	_____	_____
2. Chest pain/angina	_____	_____	_____	31. Pain/swelling of joints	_____	_____	_____
3. Abnormal EKG	_____	_____	_____	32. Cervical disc disease	_____	_____	_____
4. Ultrasounds/echo of heart	_____	_____	_____	33. Lumbar disc disease	_____	_____	_____
5. Heart catheterization	_____	_____	_____	34. Breast cancer	_____	_____	_____
6. Heart stress test	_____	_____	_____	35. Active cancer	_____	_____	_____
7. High cholesterol	_____	_____	_____	36. Anemia	_____	_____	_____
8. Atrial fibrillation	_____	_____	_____	37. Hypothyroidism	_____	_____	_____
9. Swelling of ankles/feet	_____	_____	_____	38. Hyperthyroidism	_____	_____	_____
10. Emphysema	_____	_____	_____	40. Diabetes type I	_____	_____	_____
11. Asthma	_____	_____	_____	41. Diabetes type II	_____	_____	_____
12. Sleep Apnea	_____	_____	_____	42. Diabetic eye disease	_____	_____	_____
13. Stroke	_____	_____	_____	43. Last eye exam	_____	_____	_____
14. Chronic migraines	_____	_____	_____	44. Glaucoma	_____	_____	_____
15. Seizures	_____	_____	_____	45. Neuropathy (tingling feet)	_____	_____	_____
16. Irritable bowel syndrome	_____	_____	_____	46. Gastroparesis	_____	_____	_____
17. Constipation	_____	_____	_____	(slow stomach emptying)	_____	_____	_____
18. Indigestion	_____	_____	_____	47. Seasonal Allergies	_____	_____	_____
19. Diverticuli	_____	_____	_____	48. Anxiety	_____	_____	_____
20. Crohn's disease	_____	_____	_____	49. Depression	_____	_____	_____
21. Stomach ulcer	_____	_____	_____	50. Bipolar	_____	_____	_____
22. Liver disease	_____	_____	_____	51. Anorexia	_____	_____	_____
23. Gallbladder disease	_____	_____	_____	52. Bulimia	_____	_____	_____
24. Kidney disease	_____	_____	_____	53. Lithium medication	_____	_____	_____
25. Kidney stones	_____	_____	_____	54. Females			
26. Gout	_____	_____	_____	Currently pregnant	_____	_____	_____
27. Osteoarthritis	_____	_____	_____	Currently breastfeeding	_____	_____	_____
28. Osteoporosis	_____	_____	_____	Irregular periods	_____	_____	_____
29. Osteopenia	_____	_____	_____	Pre-/ Post-menopause	_____	_____	_____

Are you currently being treated for a condition not listed? Yes No

Please explain: _____

SURGICAL / HOSPITALIZATION

HISTORY

List all operations with dates:

Year	Operation	Year	Operation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____