JC **PATIENT QUESTIONNAIRE** DATE OF VISIT: ________________________

PATIENT NAME_____________________________________DATE OF BIRTH_____________________ AGE__________

PLEASE PROVIDE THE FOLLOWING MEDICAL INFORMATION TO THE BEST OF YOUR ABILITY:

What problems are you here for today?	List any allergies to meds.	List Current Medications
	______________________ ______________________ ______________________	____ ____ ____ ____

Past Medical History(MA to elaborate on "YES" responses)

Please check the "Yes" or "No" box to indicate if you have/had any of the following illnesses.

	YES	NO		YES	NO
Arthritis/Joint Pain	___	___	Stomach or Intestinal Problems	___	___
Diabetes	___	___	Allergy Problems	___	___
High Blood Pressure	___	___	Kidney Problems	___	___
Thyroid Problems	___	___	Neurological Problems	___	___
Heart Disease/Cholesterol Prob.	___	___	Stroke	___	___
Respiratory Problems	___	___	Skin Cancer	___	___
Bleeding Disorder	___	___	Skin Disease	___	___
Cancer Other Than Skin	___	___			

PLEASE LIST YOUR CURRENT PRIMARY CARE PHYSICIAN ______________________________________

Please list any OPERATIONS/HOSPITALIZATIONS (and dates) you have ever had:

____
____
____

SOCIAL HISTORY:

Do you smoke?___YES ___NO: IF YES, AMOUNT____

If NO, Did You Smoke Previously?________________

Do you drink alcoholic beverages? ___YES ___NO

If YES, frequency______________________

Have you been exposed to HIV? ___YES ___NO

OCCUPATION:______________________________

Have you been exposed to Hepatitis B/C? ___YES ___NO

Have you ever had a blistering sunburn? ___YES ___NO

Do you use sun screen? ___YES ___NO

If YES, what SPF_____________

Have you been exposed to T.B.? ___YES ___NO

HOBBIES/LEISURE ACTIVITIES:_____________________________

FEMALE PATIENTS CHILD BEARING AGE PLEASE ANSWER THE FOLLOWING:

Are you pregnant? ___YES ___NO Breast feeding? ___YES ___NO Planning a pregnancy? ___YES ___NO

____
____
____

FAMILY HISTORY:

Please check the "YES" or "NO" box to indicate whether any relatives have OR had any of the following illnesses.

If YES, please circle which relative(s) have the problem:

	YES	NO	MOTHER	FATHER	SIBLINGS	COMMENTS
DIABETES	_____	_____	MOTHER	FATHER	SIBLINGS	______________________________
SKIN CANCER	_____	_____	MOTHER	FATHER	SIBLINGS	______________________________
BLEEDING DISORDER	_____	_____	MOTHER	FATHER	SIBLINGS	______________________________
SKIN DISEASES	_____	_____	MOTHER	FATHER	SIBLINGS	______________________________
ECZEMA	_____	_____	MOTHER	FATHER	SIBLINGS	______________________________
PSORIASIS	_____	_____	MOTHER	FATHER	SIBLINGS	______________________________
CANCER (TYPE IF KNOWN)	_____	_____	MOTHER	FATHER	SIBLINGS	______________________________

CONTINUED ON BACK

PATIENT QUESTIONAIRE

PATIENT NAME_______________________________ DATE OF BIRTH_________ AGE_____

Please provide the following medical information to the best of your ability:

Review of Systems:

1. Please check the **"YES"** or **"NO"** box to indicate if you have any of the following symptoms.

2.For any **"YES"** responses, check the **"CURRENT"** box if this symptom relates to the reason for your visit today.

		YES	NO	CURRENT
GENERAL	CHILLS			
	FEVER			
	WEIGHT LOSS/GAIN			
ALLERGY	ITCHY EYES			
	WATERY EYES			
NEURO	HEADACHES			
	SEIZURES			
	WEAKNESS IN LIMBS			
	NUMBNESS/TINGLING			
EYES	VISION CHANGES			
	PAIN/PRESSURE			
ENT	HEARING LOSS			
	DIZZINESS			
	LIGHTHEADEDNESS			
RESPIRATORY	COUGH			
	SHORTNESS OF BREATH			
CVS	CHEST PAIN			
	VARICOSE VEINS			
	ANKLE SWELLING			
G.I.	HEARTBURN			
	DIFFICULTY SWALLOWING			
G.U.	PROSTATE PROBLEMS			
	FREQUENT URINATION			
MUSK	JOINT ACHES			
	BACK PAIN			
ENDO	EXCESSIVE SWEATING			
	EXCESSIVE THIRST			
	INTOLERANCE HEAT/COLD			

		YES	NO	CURRENT
HEME/LYM	SWOLLEN GLANDS			
	BLEEDING PROBLEMS			
	RECURRENT INFECTIONS			
	SWEATING AT NIGHT			
	EASY BRUISING			
NAILS	DISCOLORED			
	PAINFUL			
	BRITTLE			
	LOOSE			
PSYCH	DEPRESSION			
	ANXIETY			
SKIN	RASH			
	MOLE CHANGES			
	REDNESS			
	RAISED SCALY AREAS			
	OPEN SORES			
	ACNE			
	GROWTHS/SPOTS			
	HAIR LOSS			
	SUN SUSCEPTIBILITY			
	ITCHING			
	HIVES			
	BLISTERING SUNBURN			
	KELOIDS SCARS			
	DRY MOUTH/NOSE			
	DRY SKIN			
	JAUNDICE			
	EVER HAD A SKIN BIOPSY?			

My signature affirms that I have completed pages 1 and 2 of this form accurately and completely to the best of my ability.

PATIENT SIGNATURE: **DATE:**

COMMENTS: ***SEE ATTACHED DICTATION***

PG 1 & 2 REV'D BY: DATE: MEDICAL ASSISTANT

PG 1 & 2 REV'D BY: DATE: PHYSICIAN SIGNATURE

Updated May 2013 gjk