

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 ___	Have you been exposed to Hepatitis B/C? ___YES ___NO
If NO, Did You Smoke Previously? _____	Have you ever had a blistering sunburn? ___YES ___NO
Do you drink alcoholic beverages? ___YES ___NO	Do you use sun screen? ___YES ___NO
If YES, frequency _____	If YES, what SPF _____
Have you been exposed to HIV? ___YES ___NO	Have you been exposed to T.B.? ___YES ___NO
OCCUPATION: _____	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	_____

PATIENT QUESTIONNAIRE

Page # 2

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			YES	NO	CURRENT
GENERAL	CHILLS				HEME/LYM	SWOLLEN GLANDS			
	FEVER					BLEEDING PROBLEMS			
	WEIGHT LOSS/GAIN					RECURRENT INFECTIONS			
ALLERGY	ITCHY EYES					SWEATING AT NIGHT			
	WATERY EYES					EASY BRUISING			
NEURO	HEADACHES				NAILS	DISCOLORED			
	SEIZURES					PAINFUL			
	WEAKNESS IN LIMBS					BRITTLE			
	NUMBNESS/TINGLING					LOOSE			
EYES	VISION CHANGES				PSYCH	DEPRESSION			
	PAIN/PRESSURE					ANXIETY			
ENT	HEARING LOSS				SKIN	RASH			
	DIZZINESS					MOLE CHANGES			
	LIGHTHEADEDNESS					REDNESS			
RESPIRATORY	COUGH					RAISED SCALY AREAS			
	SHORTNESS OF BREATH					OPEN SORES			
CVS	CHEST PAIN					ACNE			
	VARICOSE VEINS					GROWTHS/SPOTS			
	ANKLE SWELLING					HAIR LOSS			
G.I.	HEARTBURN					SUN SUSCEPTIBILITY			
	DIFFICULTY SWALLOWING					ITCHING			
G.U.	PROSTATE PROBLEMS					HIVES			
	FREQUENT URINATION					BLISTERING SUNBURN			
MUSK	JOINT ACHES					KELOIDS SCARS			
	BACK PAIN				DRY MOUTH/NOSE				
ENDO	EXCESSIVE SWEATING				DRY SKIN				
	EXCESSIVE THIRST				JAUNDICE				
	INTOLERANCE HEAT/COLD				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