PATIENT HISTORY QUESTIONNAIRE
(Must complete all pages & all columns before you can be seen)

NAME: _____ DATE: _____

MARITAL STATUS:

□ Married □ Single □ Divorced □ Separated □ Widowed

Present marriage/relationship (years): _____ Previous marriage(s)/relationship(s)(years): _____

EDUCATION:

Last school grade completed? _____

OCCUPATION: _____ **TYPE OF WORK:** _____

RETIRED: □ Yes □ No

GENERAL:

Do you limit sun exposure and/or use sun protection (SPF lotion or protective clothing)? □ Yes □ No

What type of physical activities do you perform? _____

Do you engage in any other healing or alternative therapies (i.e. Acupuncture, Massage, Hypnosis)?

□ Yes _____ □ No

Do you use vehicle safety belts? □ Yes □ No

Does your home have smoke alarms? □ Yes □ No

Do you have a living will/medical power of attorney? □ Yes □ No

(If answered "Yes" a copy is required for your medical records)

When was your last eye exam? _____

If you have not had a recent eye exam, when are you scheduled for one? _____

Do you know and practice safe sex? □ Yes □ No

(Information on avoiding sexually transmitted diseases is available upon request.)

What method(s) of family planning/birth control do you use?

_____

Do you do self-prescribed self-examinations regularly? □ Yes □ No

(MALES: Testicular self-exams; FEMALES: Breast self-exams)

When was your most recent proctoscopic/sigmoidoscopic/barium enema/colonoscopic exam? _____

PRESCRIPTION MEDICATIONS	**DOSAGE**	**FREQUENCY (once, twice, etc. Per day)**

NAME: DATE:

Non- Prescription Medications (Over the Counter drugs, Supplements, Vitamins, etc.)		

Have you taken cortisone-type drugs? □ Yes □ No
Have you ever had blood transfused? □ Yes □ No
If yes, when? _____ where? _____

KNOWN DRUG ALLERGIES TO MEDICATIONS:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Have you ever had an allergic reaction to X-ray contrast dye? □ Yes □ No
If yes, please describe: _____
Have you ever had a latex allergy? □ Yes □ No
Have you ever had a tape allergy? □ Yes □ No

FAMILY HISTORY:

	AGE	GENERAL HEALTH	LIVING/DECEASED
Father:	_____	_____	_____
Mother:	_____	_____	_____
Brothers:	_____	_____	_____
Sisters:	_____	_____	_____
Children:	_____	_____	_____

What is your usual weight? _____ How long have you been at this weight? _____

What is your main medical problem now and how long have you had it? _____

What other medical problems do you want us to know about? _____

NAME: DATE:

Please check any illnesses which have occurred in any of your **blood** relatives:

- ☐ Bleeding Tendencies ☐ Diabetes ☐ High Blood Pressure ☐ Nervous Disease
- ☐ Cancer ☐ Heart Disease ☐ Kidney Disease ☐ Stroke/TIA

Please check illnesses or conditions which **you** have had:

- ☐ Asthma ☐ Bleeding Tendencies ☐ Heart Disease ☐ Nervous Disorder
- ☐ Glaucoma ☐ HIV ☐ Kidney Disease ☐ Tuberculosis
- ☐ High Blood Pressure ☐ Jaundice ☐ Stroke/TIA ☐ Blood Clots
- ☐ Pneumonia ☐ Rheumatoid Fever ☐ Hepatitis ☐ Obesity
- ☐ Hypothyroidism ☐ Sleep Apnea ☐ Diabetes ☐ Cancer
- ☐ Hyperthyroidism ☐ Elevated Cholesterol ☐ Reflux/Peptic Ulcer ☐ Other:_____

LAST EKG, X-RAYS OR SCANS:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

PRIOR ILLNESSES, SURGERIES OR INJURIES:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Personal Habits	**Never**	**Now**	**Past**	**How much each day?**	**For how many years?**	**When did you quit?**
Tobacco Use	☐	☐	☐			
Alcohol Use	☐	☐	☐			
Recreational Drug Use	☐	☐	☐			
Coffee	☐	☐	☐			

Please check the diseases against which you have been immunized:

- ☐ Pneumococcal Pneumonia ☐ Hepatitis A ☐ Measles ☐ Rubella (German Measles)
- ☐ Polio ☐ Hepatitis B ☐ Tetanus ☐ Influenza

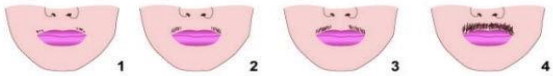
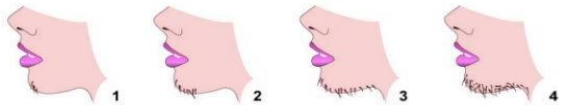
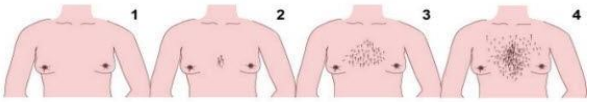
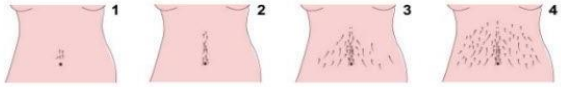
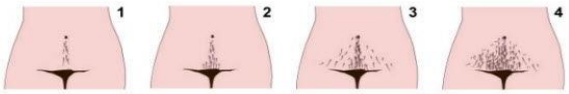
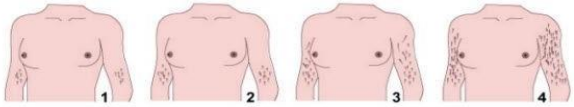
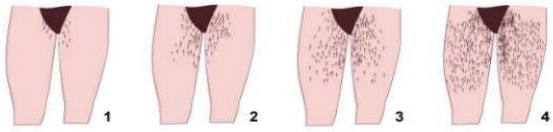
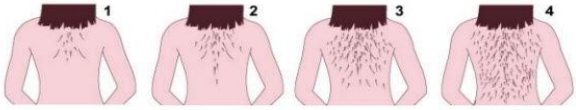
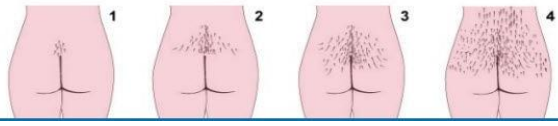
NAME: DATE:

WOMEN ONLY:

Date of last Pap test:_____ History of abnormal Pap test? □ Yes □ No
Last Period/Menstruation:_____ Periods are: □ Regular □ Irregular
Number of Pregnancies:_____
Number of Miscarriages: _____
Number of living children:_____
Last Mammogram: _____
Non-Pregnant State: Do you notice any breast secretions (milky discharge)? □ Yes □ No

Please circle your appropriate picture number in each row and place that number across each column.

For Evaluation of Hirsutism (Excess Hair) **Score Column:**

Lips		
Chin		
Chest		
Abdomen		
Pubic Area		
Arms		
Groin and Thighs		
Upper Back		
Lower Back		

Total Score:_____

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