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Amarillo Diagnostic Clinic, P.A.

PATIENT QUESTIONNAIRE - PLEASE PRINT

Full name: _____

Date: _____ Age: _____

CHIEF COMPLAINTS(List the problems about which you came to see the doctor)

1) _____

2) _____

3) _____

Referring Physician _____ Other Physician _____

PAST MEDICAL HISTORY

Medical illness: Please check any of the following medical illnesses that you now have or have ever had, or list any others that are not listed below.

- | | | |
|---|---|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Skin cancer | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Diverticulosis |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Malaria | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Any type of heart problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hiatal hernia |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Heart catheterization | <input type="checkbox"/> Treatment for depression | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tension/Anxiety/Nerves | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Osteo Arthritis | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Stress fractures |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Other |
| <input type="checkbox"/> Any type of cancer | <input type="checkbox"/> Colon polyps | |

OPERATIONS OR SURGERIES

Please list all past operations, including cataract surgery, what type of surgery it was and when it was done

Type	Date

Have you ever had a colonoscopy? _____ YES _____ NO

Describe any serious accidents or disabling injuries:

Type	Date

IMMUNIZATIONS

Last flu shot _____ Pneumonia shot Yes No When? _____

SOCIAL HISTORY

Current employment status: Disabled Part time Full time Retired Self-employed Other

What type of occupation do you (or did) you have?

Where do you live?

Current marital status? Single Married Separated Divorced Widowed Other

How many children do you have? # _____ # _____ Sons # _____ Daughters

HABITS

Have you ever smoked cigarettes regularly? Yes No If yes, how many packs per day? (avg)

How many years? Are you still smoking? Yes No If no, when did you stop?

Do you use snuff or chewing tobacco? Yes No Do you drink alcohol? Yes No

How many beers daily? How many years?

How many mixed drinks or glasses of wine daily? How many years?

Do you have any drug, nicotine or alcohol habits which concern you? Yes No

Do you regularly use sleeping pills, tranquilizers, or pain killers? Yes No

If yes, which ones?

Do you currently use marijuana, cocaine or other "recreational" drugs? Yes No

FAMILY HISTORY

Please list any diseases which tend to "run in your family" especially high blood pressure, diabetes, heart disease, cancer, gout, asthma, stomach ulcers, arthritis, allergies, epilepsy, tuberculosis, cystic fibrosis, muscle disease, stroke or thyroid disease.

Father's History

Is your Father? Alive - Age _____ Deceased - Age _____

What types of health problems if any did he have?

Mother's History

Is your Mother? Alive - Age _____ Deceased - Age _____

What types of health problems if any did she have?

Do you have any brothers?

How many? Alive - Ages _____ Deceased - Ages _____

What types of health problems do/did they have?

Do you have any sisters?

How many? Alive - Ages _____ Deceased - Ages _____

What types of health problems do/did they have?

If you served in the military:

Were you ill while in the military? Yes No What was the nature of the illness?

Did you serve overseas? Yes No If yes, where & when?

Have you traveled outside of the Amarillo area in the past year? Yes No

If so, please list the places you have been:

Please list all pets or any other animals which you may have been in contact with in the past year:

REVIEW OF SYSTEMS

Please check any of the following symptoms or problems you are currently experiencing. If the problem has been resolved, leave it blank. If you are unsure, place a question mark (?) by the medical issue.

General <input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Night sweats Do you eat a special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you exercise regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No	Skin <input type="checkbox"/> Recent change in hair distribution <input type="checkbox"/> Changes in skin color <input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Hair loss <input type="checkbox"/> Other _____	Head/Ear/Eyes/Nose/Throat <input type="checkbox"/> Diplopia (double vision) <input type="checkbox"/> Glaucoma <input type="checkbox"/> Hearing loss <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sore throat <input type="checkbox"/> Other _____
Neck <input type="checkbox"/> Neck mass <input type="checkbox"/> Neck pain <input type="checkbox"/> Neck stiffness <input type="checkbox"/> Swollen glands <input type="checkbox"/> Other _____	Respiratory <input type="checkbox"/> Cough <input type="checkbox"/> History of Tuberculosis <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Other _____	Breast/GYN <input type="checkbox"/> Breast discharge <input type="checkbox"/> Breast swelling <input type="checkbox"/> Breast mass <input type="checkbox"/> Breast tenderness <input type="checkbox"/> Menses: Last one? _____ <input type="checkbox"/> # Miscarriage _____ <input type="checkbox"/> Other _____
Cardiovascular <input type="checkbox"/> Chest pain <input type="checkbox"/> Edema (swelling) _____ <input type="checkbox"/> Fast/Irregular heartbeat <input type="checkbox"/> Orthopnea (trouble breathing while lying down) <input type="checkbox"/> Other _____	Gastrointestinal <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Constipation/Diarrhea <input type="checkbox"/> Reflux <input type="checkbox"/> Other _____	Genitourinary <input type="checkbox"/> Blood in urine <input type="checkbox"/> Dysuria (pain with urination) <input type="checkbox"/> Frequency of urination <input type="checkbox"/> Discharge <input type="checkbox"/> Nocturia (excessive urination at night) <input type="checkbox"/> History of malignancy (cancer) <input type="checkbox"/> Other _____
Musculoskeletal <input type="checkbox"/> Arthritis <input type="checkbox"/> Back pain <input type="checkbox"/> Joint pain <input type="checkbox"/> Other _____	Neurological <input type="checkbox"/> Headaches <input type="checkbox"/> Seizures <input type="checkbox"/> Strokes <input type="checkbox"/> Other _____	Psychological <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/> Other _____
Endocrine <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Other _____	Hematological <input type="checkbox"/> Anemia <input type="checkbox"/> Easy bleeding <input type="checkbox"/> Easy bruising <input type="checkbox"/> Other _____	Other

Patient Signature

Physician Signature

Date

Date