# Patient Questionnaire

Name: _____ Date: _____

Chief Complaint: _____

_____

**Past Medical History:** Do you suffer from any of the following:

| | No | Yes |
|---|---|---|
| Diabetes (Problems with blood sugar) | [ ] | [ ] |
| Congestive heart failure | [ ] | [ ] |
| Angina (chest pain) | [ ] | [ ] |
| Previous heart attack-When_____ | [ ] | [ ] |
| Heart murmur | [ ] | [ ] |
| High blood pressure | [ ] | [ ] |
| High cholesterol | [ ] | [ ] |
| Stroke | [ ] | [ ] |
| Cancer | [ ] | [ ] |
| Seizures | [ ] | [ ] |
| Bleeding disorders | [ ] | [ ] |
| Thyroid disorders | [ ] | [ ] |
| Asthma | [ ] | [ ] |
| Emphysema | [ ] | [ ] |
| Migraine headaches | [ ] | [ ] |
| Blood Clots or DVT | [ ] | [ ] |

Other: _____

| | No | Yes |
|---|---|---|
| Kidney disorders | [ ] | [ ] |
| Gastrointestinal disorders | [ ] | [ ] |
| Tuberculosis | [ ] | [ ] |
| Sleep apnea | [ ] | [ ] |
| Arthritis: | [ ] | [ ] |
| If yes Rheumatoid | [ ] | [ ] |
| Osteo | [ ] | [ ] |
| Lupus | [ ] | [ ] |
| Sarcoidosis | [ ] | [ ] |
| Hepatitis, cirrhosis, liver disease | [ ] | [ ] |
| Back or neck problems | [ ] | [ ] |
| Difficulty with anesthesia | [ ] | [ ] |
| Glaucoma | [ ] | [ ] |
| Cataracts | [ ] | [ ] |
| Rheumatic fever | [ ] | [ ] |
| Depression | [ ] | [ ] |
| Prostate problems | [ ] | [ ] |
| Sickle Cell | [ ] | [ ] |

**Past Surgical History:**

| Please list any surgery that you have had: | No | Yes | |
|---|---|---|---|
| Heart bypass surgery | [ ] | [ ] | |
| Carotid surgery | [ ] | [ ] | |
| Appendectomy | [ ] | [ ] | |
| Gall bladder surgery | [ ] | [ ] | |
| Foot/Ankle surgery | [ ] | [ ] | *If so, specify*_____ |

Other: _____

Have you ever had radiation treatment: [ ] [ ]

| **Allergies:** | No | Yes |
|---|---|---|
| Do you have allergies to medications: | [ ] | [ ] |
| Please Specify: _____ | | |
| Latex | [ ] | [ ] |
| Shellfish | [ ] | [ ] |
| X-ray contrast | [ ] | [ ] |

**History Reviewed By Doctor :**_____

**Medications:**

Please list all medications that you currently take:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

| **Do you currently take:** | **No** | **Yes** |
|---|---|---|
| Aspirin | [ ] | [ ] |
| Ginkgo Biloba | [ ] | [ ] |
| Motrin/Ibuprofen/Advil | [ ] | [ ] |

Other herbal preparations: _____

| **Social History:** | **No** | **Yes** |
|---|---|---|
| Do you now, or have you ever smoked: | [ ] | [ ] |

If yes, how many years? _____

If yes, how much do you smoke per day?_____

If you no longer smoke, when did you quit? _____

| | | |
|---|---|---|
| Do you drink alcohol? | [ ] | [ ] |

If so, how much daily or weekly? _____

| Do you drink: | **No** | **Yes** |
|---|---|---|
| Coffee | [ ] | [ ] How much a day?_____ |
| Soda with caffeine | [ ] | [ ] How much a day?_____ |
| Tea | [ ] | [ ] How much a day?_____ |

| **Family History:** | **No** | **Yes** | |
|---|---|---|---|
| Has anyone in your family ever suffered from any of the following? | | | Who? |
| Bleeding problems | [ ] | [ ] | _____ |
| Cancer | [ ] | [ ] | _____ |
| Diabetes | [ ] | [ ] | _____ |
| Heart disease | [ ] | [ ] | _____ |
| Hypertension | [ ] | [ ] | _____ |
| Thyroid disorders | [ ] | [ ] | _____ |
| Other_____ | [ ] | [ ] | _____ |

| | | |
|---|---|---|
| Do you have a Living Will? (for patients 18 yrs. & above) | [ ] | [ ] |

Do you or your caregiver have any of the following barriers that may affect your medical care?

| | | |
|---|---|---|
| Cultural / Religious Barrier | [ ] | [ ] |
| Language Barrier | [ ] | [ ] |
| Visual Barrier | [ ] | [ ] |
| Auditory Barrier | [ ] | [ ] |