

Patient Name: _____

DOB: _____

PATIENT HISTORY QUESTIONNAIRE

Your health is important to us. So that we may better serve and care for you, please take a few moments to complete the following questionnaire which will be used to update your electronic medical record.

1. CHIEF COMPLAINT/CONCERN (Please note if you are currently feeling pain.):

2. CURRENT MEDICATIONS: Please list any prescriptions or over-the-counter medications you currently take. Please be sure to let your provider know if you are currently, or have taken in the past, any blood thinning medications.

Please provide your preferred pharmacy's information:

Pharmacy Name: _____

Phone/Fax Number and/or Address: _____

3. ALLERGIES: Please list any allergies to medications, food, or environmental factors:

4. PAST MEDICAL HISTORY: Please check any of the following items for which you have a history:

- | | | | |
|---|--|---|---|
| <input type="radio"/> Unremarkable | <input type="radio"/> Dermatitis Herpetiformis | <input type="radio"/> Depression | <input type="radio"/> Osteoporosis |
| <input type="radio"/> Pre-Cancerous Lesions/AKs | <input type="radio"/> Lichen Planus | <input type="radio"/> Diabetes – Type _____ | <input type="radio"/> Rheumatoid Arthritis |
| <input type="radio"/> Basal Cell Skin Cancer | <input type="radio"/> Sarcoidosis | <input type="radio"/> Blood Clots | <input type="radio"/> Seizure Disorder |
| <input type="radio"/> Squamous Cell Skin Cancer | <input type="radio"/> Asthma | <input type="radio"/> GI Bleed | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Melanoma | <input type="radio"/> Atrial Fibrillation | <input type="radio"/> GERD | <input type="radio"/> Heart Disease |
| <input type="radio"/> Eczema | <input type="radio"/> Anemia | <input type="radio"/> Hemochromatosis | <input type="radio"/> Urinary Tract Infection (recurrent) |
| <input type="radio"/> Psoriasis | <input type="radio"/> Autoimmune Disorder | <input type="radio"/> High Cholesterol | <input type="radio"/> Varicose Veins/Phlebitis |
| <input type="radio"/> Atypical mole | <input type="radio"/> Blood Transfusions | <input type="radio"/> High Blood Pressure | <input type="radio"/> Abnormal PAP Smear |
| <input type="radio"/> Bullous Dermatoses | <input type="radio"/> Cerebrovascular Disease | <input type="radio"/> Hypothyroidism | <input type="radio"/> Ulcers |
| <input type="radio"/> Cutaneous T-Cell Lymphoma | <input type="radio"/> Cirrhosis | <input type="radio"/> Hyperthyroidism | <input type="radio"/> Breast Cancer |
| <input type="radio"/> Discoid Lupus | <input type="radio"/> Stroke(s) | <input type="radio"/> Hepatitis _____ | |
| | <input type="radio"/> Lung Disease/COPD | <input type="radio"/> Kidney Stones | |
| | <input type="radio"/> Colon Cancer | <input type="radio"/> Heart Attack | |
| | <input type="radio"/> Crohn's Disease | <input type="radio"/> Neurologic Disorder | |
| | <input type="radio"/> Kidney Problems | <input type="radio"/> Osteoarthritis | |

OTHER/COMMENTS (Past Medical History cont...) _____

5. PAST SURGICAL HISTORY: Please check any of the following items for which you have a history:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Unremarkable | <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Aorto-Femoral Bypass |
| <input type="checkbox"/> Excision of Dysplastic Mole | <input type="checkbox"/> Breast Surgery | <input type="checkbox"/> Kyphoplasty | <input type="checkbox"/> Rotator Cuff Repair |
| <input type="checkbox"/> MOHS Procedure | <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Lumpectomy | <input type="checkbox"/> total abdominal hysterectomy with BSO |
| <input type="checkbox"/> Removal of Basal Cell CA | <input type="checkbox"/> Coronary Artery Bypass Graft | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> total abdominal hysterectomy |
| <input type="checkbox"/> Removal of Squamous Cell CA | <input type="checkbox"/> Carotid Endarterectomy | <input type="checkbox"/> Mitral Valve Replacement | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Removal of Melanoma | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Nephrectomy: Native | <input type="checkbox"/> Tunneled Dialysis Catheter |
| <input type="checkbox"/> Sentinel Lymph Node Biopsy | <input type="checkbox"/> Cataract Extraction | <input type="checkbox"/> Nephrectomy: Transplant | <input type="checkbox"/> Sleep Apnea Surgery/UPPP |
| <input type="checkbox"/> Anesthesia Problems – No | <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Urinary Incontinence Surgery |
| <input type="checkbox"/> Anesthesia Problems – Yes | <input type="checkbox"/> Colon Resection | <input type="checkbox"/> Parathyroidectomy | <input type="checkbox"/> Vertebroplasty |
| <input type="checkbox"/> Surgical Complications – No | <input type="checkbox"/> Craniotomy | <input type="checkbox"/> Pneumonectomy | |
| <input type="checkbox"/> Surgical Complications – Yes | <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Percutaneous transluminal coronary angioplasty | |
| <input type="checkbox"/> Post-Op Delirium | <input type="checkbox"/> Hemorrhoidectomy | | |
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Hip replacement | | |
| <input type="checkbox"/> Abdominal Surgery | <input type="checkbox"/> IV Pain Procedures | | |
| <input type="checkbox"/> AV Fistula Creation | <input type="checkbox"/> Knee Arthroscopy | | |
| <input type="checkbox"/> AV Graft | | | |
| <input type="checkbox"/> Aortic Valve Replacement | | | |

OTHER/COMMENTS (Surgical History cont...) _____

6. PAST HOSPITALIZATIONS: Please list any prior hospitalizations you have had; include date of admission and reason for the admission. _____

7. FAMILY HISTORY: Please check any of the following for which there is history of within your immediate family; indicate relative and age of onset. *Example: FH Breast Ca – mother, age 66.*

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Unremarkable Family History | <input type="checkbox"/> Asthma | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Colon Cancer |
| <input type="checkbox"/> Unknown Family History | <input type="checkbox"/> Atypical Mole | <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> ----- | <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Squamous Cell Skin Cancer | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Unknown Cancer |
| <input type="checkbox"/> Eczema | | <input type="checkbox"/> Blood Clots | |
| | | <input type="checkbox"/> Breast Cancer | |

OTHER/COMMENTS (Family History cont...) _____

8. SOCIAL HISTORY: If you answer yes to any items, please explain below with dates, locations, etc.

Marital Status

- Single
- Married
- Divorced
- Separated
- Widowed

Sun Exposure

- Rare
- Occasional
- Frequent
- Prolonged
- Blistering Sunburns

Nicotine Use

- Current Smoker
- Former Smoker
- Never Smoked

Alcohol or Drug Use

- Alcohol Use – No
- Alcohol Use – Yes
drinks per week: _____
- Drug Use – No
- Drug Use – Yes
Please explain below.

Sunscreen Use

- Never
- Rarely
- Occasionally
- Frequently
- Most of the time
- All of the time

Tanning Bed Usage

- Never
- Rarely
- Occasionally
- Frequently

Travel History

- No
- Yes

OTHER/COMMENTS (Social History cont...) _____

9. ADDITIONAL INFORMATION: If there are any additional issues or concerns that you would like your provider to be aware of, please indicate those here. _____

10. How did you hear about us? _____

Please return all paperwork to the front desk to complete your check-in process.