Valley Family Practice

We care for you.

PATIENT QUESTIONNAIRE

Check all applicable spaces and give additional information where indicated.

NAME: _____ **Date of Birth** _____

AGE: _____ **TODAY'S DATE:** _____

OCCUPATION: _____

ALLERGIES:

_____Penicillin
_____Codeine
_____Aspirin
_____Tetanus
_____Morphine
_____Sulfas
_____Tetracycline
_____Others

CURRENT MEDICATIONS:

Drug Name Frequency

_____
_____
_____
_____

PAST MEDICATIONS:

_____Birth Control
_____Thyroid
_____Cortisone
_____Insulin
_____Heart Pills
_____Water Pills
_____Others

_____

PAST HISTORY:

_____Diabetes
_____High Blood Pressure
_____Thyroid Disease
_____Goiter
_____Cancer
_____Leukemia
_____Blood Disease
_____Anemia
_____Blood Transfusion
_____Arthritis
_____Skin Disease
_____Gonorrhea
_____Syphilis
_____Alcoholism
_____Hives

_____Heart Disease
_____Heart Attack
_____Congestive Failure
_____Rheumatic Fever
_____Heart Murmur
_____Irregular Rhythm
_____Liver Disease
_____Yellow Jaundice
_____Hepatitis
_____Lung Disease
_____Asthma
_____Bronchitis
_____Emphysema
_____Pneumonia
_____Psychiatric Problem

_____Bowel Disease
_____Colitis
_____Stomach Disease
_____Ulcers
_____Tuberculosis
_____Gallbladder Disease
_____Kidney Disease
_____Kidney Stones
_____Bladder Trouble
_____Phlebitis
_____Blood Clots
_____Concussion
_____Seizure
_____Meningitis
_____Depression

_____Other Serious Illness: _____

SURGERY (YEAR)

_____Appendix
_____Gallbladder
_____Hernia
_____Hysterectomy
_____Ovaries/tubes
_____Hemorrhoids
_____Chest
_____Other

OTHER HOSPITALIZATIONS (YEAR)

_____ _____
_____ _____
_____ _____
_____ _____

FAMILY HISTORY (RELATION) Siblings/grandparents/parents

_____Diabetes _____
_____Heart Disease _____
_____Stroke _____
_____Alcoholism/Addictions _____
_____High Blood Pressure _____
_____Depression/Schizophrenia/Bipolar _____
_____Cancer _____

HABITS (AMOUNT): How much/how often?

_____Alcohol _____
_____Tobacco _____
_____Coffee _____
_____Other Caffeine _____
_____Marijuana _____
_____Hard Drugs _____
_____Other _____

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NAME: _____

SYSTEMS REVIEW:
_____Frequent Headaches
_____Neck Pains
_____Lumps or Swelling
_____Difficulty Swallowing

EYES:
_____Blurred Vision
_____Seeing Double
_____Seeing Halos
_____Eye Pain
_____Watering
_____Itching
_____Wear Eyeglasses
_____Date Last Exam

EARS:
_____Difficulty Hearing
_____Buzzing or Ringing
_____Ear Aches
_____Frequent Infections
_____Drainage
_____Use Hearing Aid

MOUTH:
_____Dental Problems
_____Frequent Sores
_____Swelling or Lumps

NOSE & THROAT:
_____Frequent Nosebleeds
_____Sinus Problems
_____Nasal Congestion
_____Frequent Sore Throats
_____Hoarse Voice

SKIN:
_____Rashes
_____Sores
_____Change in Mole
_____Lumps or Swelling
_____Bleed Easily
_____Bruise Easily
_____Itching

NEUROLOGICAL:
_____Seizures
_____Numbness
_____Trembling
_____Fainting Spells
_____Change in Handwriting

CARDIOVASCULAR:
_____Chest Pains
_____Dizziness
_____Racing Heart
_____Shortness of Breath
_____Swollen Ankles
_____Leg Cramps
_____Irregular Pulses
_____Poor Circulation

RESPIRATORY:
_____Wheezing
_____Frequent Cough
_____Cough Up Phlegm
_____Cough Up Blood
_____Excessive Sweating
_____Sit Up To Sleep
_____Trouble Breathing

DIGESTIVE:
_____Frequent Indigestion
_____Heartburn
_____Frequent Belching
_____Bloated Stomach
_____Nausea or Vomiting
_____Spit Up Blood
_____Constipation
_____Diarrhea
_____Black Stools
_____Grey Stools
_____Rectal Pain
_____Rectal Bleeding
_____Change in Stools

URINARY:
_____Frequency
_____Urgency
_____Burning or Pain
_____Trouble Starting
_____Wet Pants or Bed
_____Dark Urine
_____Bloody Urine

MUSCULOSKELETAL:
_____Joint Pains
_____Aching Muscles
_____Swollen Joints
_____Weakness
_____Tingling
_____Handicapped

GENERAL:
_____Hot or Cold
_____Poor Appetite
_____Always Tired
_____Trouble Sleeping
_____Lack of Exercise
_____Always Thirsty
_____Often Crying
_____Depressed
_____Hopeless Outlook
_____Lose Temper Often
_____Considering Suicide
_____Weight Loss
_____Weight Gain
_____Sexual Difficulty

MALE GENITAL:
_____Lumps on Testicles
_____Painful Testicles
_____Prostate Trouble
_____Discharge
_____Burning

FEMALE GENITAL:
_____Irregular Periods
_____Abnormal Bleeding
_____Vaginal Discharge
_____Severe Cramps
_____Hot Flashes
_____Menopause
_____Post-Menopause
_____Lumps in Breasts
_____Had C-Section
_____Had Abortion
_____# of Pregnancies
_____# of Living Children
_____Date of Last Period
_____Date of Last PAP

MISCELLANEOUS:
_____

_____

_____

_____

_____

_____

To the best of my knowledge, the above information is correct and accurate.

Date/initials_____ Date/initials_____ Date/initials_____ Date/initials_____

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