MEDICAL QUESTIONNAIRE

___Tom N Galouzis, MD FACS	___Thomas W Shin, MD FACS	___Brendan P Frawley, MD FACS
___Mark A. Mueller, MD FACS	___Christopher R. Mussman, DO	___Jonathan G Patterson, DO
___James Siatras, DO	___Sha-Ron Jackson-Johnson, MD	___Eric Woo, DO

Patient Name: _____ Today's Date:_____ Birthdate: _____
Age:_____ Sex: ___Female ___Male
Who is your family doctor? _____
Please list name and address of the pharmacy you use: _____

What is the reason for your visit? Please list chief complaints: _____
_____.

PLEASE (X) SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR.

GENERAL		**GENITO-URINARY**		**CARDIOVASCULAR**		**SKIN**	
Chills		Blood in urine		Chest pain		Bruise easily	
Depression		Frequent urination		High blood pressure		Hives	
Dizziness		Lack of bladder control		Irregular heart beat		Itching	
Fainting		Painful urination		Low blood pressure		Change in moles	
Fever		**GASTROINTESTINAL**		Poor circulation		Rash	
Forgetfulness		Appetite poor		Rapid heart beat		Sore that won't heal	
Headache		Bloating		Swollen feet/ankles		Anemia	
Loss of sleep		Bowel Changes		Varicose veins		**MEN ONLY**	
Nervousness		Constipation		**EYE, EAR, NOSE and THROAT**		Breast lump	
Numbness		Diarrhea		Bleeding gums		Erection difficulties	
Sweats		Excessive hunger		Blurred vision		Lump in testicles	
Weight loss		Excessive thirst		Difficulty swallowing		Other	
MUSCLE		Gas		Double vision			
JOINT/BONE		Hemorrhoids		Earache		**WOMEN ONLY**	
Pain, weakness, Or numbness in:		Indigestion		Hay fever		Abnormal pap smear	
Arms		Nausea or Vomiting		Hoarseness		Bleeding between periods	
Hands		Rectal bleeding		Loss of hearing		Extreme menstrual pain	
Back		Abdominal/stomach pain		Nosebleeds		Hot flashes	
Feet		Vomiting blood		Persistent cough		Painful intercourse	
Hips		**RESPIRATORY**		Ringing in the ears		Vaginal discharge	
Legs		Cough w/phlegm? Dry?		Sinus problems		Other	
Neck		Shortness of breath		Vision-Flashes/Halos			
Shoulders		Wheezing					

PLEASE (X) CONDITIONS YOU HAVE OR HAD IN THE PAST.

AIDS		Chemical Dependency		High Cholesterol		Prostrate Problems	
Alcoholism		Chicken Pox		HIV Positive		Psychiatric Care	
Anemia		Diabetes		Kidney Disease		Rheumatic Fever	
Anorexia		Emphysema		Liver Disease		Scarlet Fever	
Appendicitis		Epilepsy		Measles		Stroke	
Arthritis		Glaucoma		Migraine Headaches		Suicide Attempt	
Asthma		Goiter		Miscarriage		Thyroid Problems	
Bleeding Disorder		Gonorrhea		Mononucleosis		Tonsillitis	
Breast Lump		Gout		Multiple Sclerosis		Tuberculosis	
Bronchitis		Heart Disease		Mumps		Typhoid Fever	
Bulimia		Hepatitis		Pacemaker		Ulcers	
Cancer		Hernia		Pneumonia		Vaginal infections	
Cataracts		Herpes		Polio		Venereal disease	

Please list any medications you are now taking. Be sure to indicate the dosage and frequency:

Do you have any ALLERGIES to medications? ____**NO** _____**YES**
If yes, list the drug(s) and describe the reaction:

HEALTH HABITS: Check (x) which substances you use and describe how much you use:

__ **Caffeine/How much** _____ ___**Tobacco/How much** _____

__**Drugs/How much** _____ ___ **Alcohol** _____

Have you ever had a blood transfusion? ____ **NO** ____ **Yes (Give approximate date** _____**)**

******MEDICAL HISTORY******

YEAR	TYPE OF MEDICAL PROBLEM	TREATMENT	DOCTOR	HOSPITALIZED?

******PAST SURGERY (OPERATIONS) – Please list in order**

YEAR	TYPE OF OPERATION	REASON FOR SURGERY	DOCTOR	HOSPITAL

******RADIATION THERAPY PATIENTS******

STARTED? MONTH/YEAR	STOPPED? MONTH/YEAR	AREA OF BODY TREATED	DOCTOR	HOSPITAL OR FACILITY

******FAMILY HISTORY******

RELATION	AGE	STATE OF HEALTH	AGE OF DEATH	CAUSE OF DEATH
FATHER				
MOTHER				
BROTHERS				
SISTERS				

Check (x) if you or your blood relatives had any of the following:

	Disease	You	Relationship to you
☐	Breast Cancer	☐	
☐	Ovarian Cancer	☐	
☐	Other Cancers/List below	☐	
☐	Diabetes	☐	
☐	Heart Disease or stroke	☐	
☐	High Blood Pressure	☐	
☐	Kidney Disease	☐	
☐	Tuberculosis	☐	
☐	Family history of other diseases: List Below:	☐	

*******WOMEN ONLY*******

Breast Health History:

Past breast problems (list): _____

Last mammogram: Date: _____ **Where:** _____

Are you now taking hormones or birth control pills? ☐ **NO** ☐ **YES**

Have you ever taken birth control pills or hormones? ☐ **NO** ☐ **YES** **TYPE:** _____

HOW LONG? _____ **WHEN STOPPED?** _____

Do you perform self-breast exams? ☐ **NO** ☐ **YES** **Frequency?** _____

Age at onset of periods: _____ **Number of pregnancies:** _____

Number of births: _____

Number of abortions: _____

Age at first childbirth: _____

Have you gone through menopause? ☐ **NO** ☐ **YES**

Are you pregnant? ☐ **NO** ☐ **YES**