Amarillo Diagnostic Clinic, P.A.

SEAN MILLIGAN, M.D.

PATIENT QUESTIONNAIRE - PLEASE PRINT

Full name:_____

Please answer all questions. If you do not know the answer, insert a question mark in the space.

Which hand do you prefer to use? (Circle) Left Right

MAJOR COMPLAINT(S): List the main reason(s) why you are here and when each problem began.

1) _____ Date started_____

2)_____ Date started_____

3)_____ Date started_____

PAST MEDICAL AND SURGICAL HISTORY

1) _____ Surgeon_____ Date_____

2)_____ Surgeon_____ Date_____

3)_____ Surgeon_____ Date_____

4)_____ Surgeon_____ Date_____

LIST ALL CHRONIC MEDICAL CONDITIONS

1) _____ Date of onset_____

2)_____ Date of onset_____

3)_____ Date of onset_____

4)_____ Date of onset_____

CHECK ALL OF THE FOLLOWING CONDITIONS WHICH YOU HAVE EXPERIENCED

☐ Anemia
☐ Blood clots
☐ Cancer
☐ Diabetes
☐ Kidney stones
☐ Liver disease
☐ STD
☐ Thyroid disease
☐ _____

☐ Exposure to poisons
☐ Seizures – as child
☐ Seizures – as adult
☐ Stroke
☐ Head injury
☐ Coma
☐ Neck injury
☐ Back injury
☐ _____

☐ Physical abuse
☐ Sexual abuse
☐ Psychiatric treatment

USE OF THE FOLLOWING:

☐ Alcohol
☐ Tobacco
☐ Illegal drugs
☐ Other
☐ _____

HAS ANY BLOOD RELATIVE EVER HAD ANY OF THE FOLLOWING? IF SO, INDICATE RELATIONSHIP

_____ Epilepsy/Seizures _____ Cancer _____ Stroke

_____ Headache _____ Diabetes _____ Tremor

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING.
Give the name, the strength of each dose, how often taken, and when you began taking it.

Name of medication	Strength	How often	When began

PLEASE LIST ALL MEDICATIONS THAT YOU ARE ALLERGIC TO, WITH TYPE OF REACTION

Name of medication	Strength	Reaction

SOCIAL HISTORY

Current marital status? □ Single □ Married □ Separated □ Divorced □ Widowed □ Other

Number of children_____ Years of school_____ Degree_____

Occupation_____

FAMILY HISTORY
Please give the following information about the health of your immediate family.

Father's History

Is your Father? □ Alive – Age _____ □ Deceased – Age _____

Major health problems and/or cause of death?

Mother's History

Is your Mother? □ Alive – Age _____ □ Deceased – Age _____

Major health problems and/or cause of death?

Do you have any brothers?

How many? □ Alive – Ages _____ □ Deceased – Ages _____

Major health problems and/or cause of death?

Do you have any sisters?

How many? □ Alive – Ages _____ □ Deceased – Ages _____

Major health problems and/or cause of death?

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

□ Fatigue
□ Fever

Head/Ear/Eyes/Nose/Throat

□ Temporary blindness
□ Change in hearing
□ Change in smell
□ Change in vision
□ Chewing problems
□ Dryness of eyes
□ Dryness of mouth
□ Ringing in ears
□ Seasonal allergies
□ Sinus problems
□ Spinning sensation

Respiratory

□ History of Tuberculosis
□ Shortness of breath
□ Decreased exercise tolerance

Cardiovascular

□ Heart problems
□ Calf cramps
□ Loss of consciousness

Neurological

□ Headaches
□ Decreased memory
□ Difficulty speaking
□ Double vision
□ Drowsiness
□ Falls
□ Localized weakness
□ Numbness
□ Insomnia
□ Loss of bowel control
□ Loss of bladder control
□ Muscle spasms
□ Poor coordination
□ Slurred speech
□ Tingling
□ Tremor
□ Trouble walking
□ Unsteadiness

Skin

□ Rash
□ New lesions

Neck

□ Neck pain
□ Swollen glands

Gastrointestinal

□ Abdominal pain
□ Nausea
□ Black or bloody stool
□ Heartburn
□ Persistent diarrhea

Musculoskeletal

□ Arthritis
□ Back pain
□ Joint pain
□ Other_____

Psychiatric

□ Anxiety
□ Depression
□ Suicidal

Genitourinary

□ Sexual dysfunction
□ Recurrent bladder infections

Endocrine

□ Cold intolerance
□ Heat intolerance
□ Thyroid problems
□ Other_____

_____ _____

Patient Signature **Date**

We appreciate your cooperation in completing this form for your physician.