ACCT#_____

BSA Amarillo Diagnostic Clinic

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PATIENT QUESTIONNAIRE – PLEASE PRINT

Full Name: _____

Date:_____Age:_____

CHIEF COMPLAINTS (List the problems about which you came to see the doctor)

1) _____

2)_____

3)_____

Referring Physician_____Other Physician_____

PAST MEDICAL HISTORY

Medical illness: Please check any of the following medical illnesses that you now have or have ever had, or list any others that are not listed below.

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Chronic Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Any type of heart problems
- ☐ Heart attack
- ☐ Heart catheterization
- ☐ Rheumatic Fever
- ☐ High blood pressure
- ☐ Stroke
- ☐ High cholesterol
- ☐ Any type of cancer
- ☐ Skin cancer
- ☐ Psoriasis
- ☐ Diabetes
- ☐ Malaria
- ☐ Sexually transmitted disease
- ☐ Tuberculosis
- ☐ Thyroid disease
- ☐ Treatment for depression
- ☐ Tension/Anxiety/Nerves
- ☐ Osteo Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Gallbladder disease
- ☐ Colon polyps
- ☐ Pancreatitis
- ☐ Diverticulosis
- ☐ Liver disease
- ☐ Hepatitis
- ☐ Stomach ulcers
- ☐ Hiatal hernia
- ☐ Kidney problems
- ☐ Kidney stones
- ☐ Miscarriage
- ☐ Blood Clots
- ☐ Stress fractures
- ☐ Other

OPERATIONS OR SURGERIES

Please list all past operations, including cataract surgery, what type of surgery it was and when it was done

Type	Date

PHARMACY

_____

_____

ALLERGIES

Please list any medications or products you have taken which cause a <u>true</u> allergic reaction (hives, itching, rash, or difficulty breathing):_____

_____

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING. BE SURE TO INCLUDE ANY HORMONES, VITAMIN E, NIACIN, FISH OIL, CO-Q 10 & ASPIRIN		
Name	**Dose (ie # of tablets)**	**How often**

IMMUNIZATIONS

Last Flu shot _____ Pneumonia shot ☐Yes ☐ No When? _____

SOCIAL HISTORY

Current Employment Status: ☐Disabled ☐ Part time ☐ Full time ☐Retired ☐ Self Employed ☐ Other

What type of occupation do you (or did) you have?

If retired, please list previous.

Current Marital Status? ☐Single ☐ Married ☐ Separated ☐ Divorced ☐Widowed ☐Other

HABITS

Have you ever smoked cigarettes regularly? ☐ Yes ☐No If yes, how many packs peer day? (avg)

How many years? Are you still smoking? ☐Yes ☐ No If no, when did you stop?

Do you use snuff or chewing tobacco? ☐Yes ☐ No Do you drink alcohol? ☐Yes ☐ No

How many beers daily? _____ How many years? _____

How many mixed drinks or glasses of wine? _____ How many years? _____

Do you currently use marijuana, cocaine or other "recreational" drugs? ☐Yes ☐ No

FAMILY HISTORY

Please list any diseases which tend to "run in your family" epscially high blood pressure, diabetes, heart disease, cancer, gout asthma, stomach ulcers, arthritis, allergies, epilepsy, tuberculosis, cystic fibrosis, muscle disease, stroke, or thyroid disease.

Father's History

Is your Father? ☐Alive – Age _____ ☐ Deceased – Age_____

What type of health problems, if any, did he have?

Mother's History

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

What type of health problems, if any, did he have? _____

Do you have any brothers?

How many? ☐Alive ☐ Deceased

What types of health problems do/did they have? _____

Do you have any sisters?

How many? ☐ Alive ☐ Deceased

What type of health problems do/did they have? _____

If you served in the military:

Were you ill in the military? ☐ Yes ☐ No What was the nature of the illness?_____

Did you serve overseas? ☐ Yes ☐ No If yes, where & when? _____

Have you traveled outside of the Amarillo area in the past year? ☐ Yes ☐ No

If so, please list the places you have been: _____

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	**Skin**	**Head/Ear/Eyes/Nose/Throat**
□ Weight loss	□ Recent change in hair distribution	□ Diplopia (double vision)
□ Weight gain	□ Changes in skin color	□ Glaucoma
□ Fatigue	□ Itching	□ Hearing loss
□ Fever	□ Rash	□ Nose bleeds
□ Night sweats	□ Hair loss	□ Sore throat
Do you eat a special diet? ☐Yes ☐No	□ Other_____	□ Other_____
Do you exercise regularly? ☐Yes ☐No		
Neck	**Respiratory**	**Breast/GYN**
□ Neck mass	□ Cough	□ Breast discharge
□ Neck pain	□ History of Tuberculosis	□ Breast swelling □ Breast mass
□ Neck stiffness	□ Shortness of breath	□ Breast tenderness
□ Swollen glands	□ Wheezing	□ Menses:Last one?_____
□ Other_____	□ Other_____	□ # Miscarriage _____
		□ Other_____
Cardiovascular	**Gastrointestinal**	**Genitourinary**
□ Chest pain	□ Abdominal pain	□ Blood in urine
□ Edema (swelling)_____	□ Nausea	□ Dysuria (pain with urination)
□ Fast/Irregular heartbeat	□ Vomiting	□ Frequency of urination
□ Orthopnea (trouble breathing while lying down)	□ Constipation/Diarrhea	□ Discharge
	□ Reflux	□ Nocturia (excessive urination at night)
□ Other_____	□ Other_____	□ History of malignancy (cancer)
		□ Other_____
Musculoskeletal	**Neurological**	**Psychological**
□ Arthritis	□ Headaches	□ Anxiety
□ Back pain	□ Seizures	□ Depression
□ Joint pain	□ Strokes	□ Insomnia
□ Other_____	□ Other_____	□ Other_____
Endocrine	**Hematological**	**Other**
□ Cold intolerance	□ Anemia	
□ Heat intolerance	□ Easy bleeding	
□ Thyroid problems	□ Easy bruising	
□ Other_____	□ Other_____	

_____ _____

Patient Signature **Physician Signature**

_____ _____

Date **Date**

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