Pamela A. Wright, M.D., FACS

PATIENT HISTORY QUESTIONNAIRE

DATE: ____________________

Patient Name: ________________________________ DOB:________________ Age:__________

Reason for today's visit: ____
Drug Allergies:____
Medications – List all with doses--____
____
____

PAST MEDICAL HISTORY

Do you have or have you ever had the following problems:

	Yes	No	Details		Yes	No	Details
Stroke	___	___	___________	Stomach/intestinal problem	___	___	_____________
Seizures	___	___	___________	Arthritis	___	___	_____________
Diabetes	___	___	___________	Anemia	___	___	_____________
High blood pressure	___	___	___________	Bleeding/clotting disorder	___	___	______________
High cholesterol	___	___	___________	Hepatitis	___	___	______________
Chest pain (angina)	___	___	___________	HIV/AIDS	___	___	______________
Heart Attack	___	___	___________	Kidney disease	___	___	______________
Heart disease	___	___	___________	Thyroid Disease	___	___	______________
Asthma	___	___	___________	Cancer	___	___	______________
Lung disease	___	___	___________	Depression,anxiety, etc	___	___	______________
Breast disease	___	___	___________	Other medical problems	___	___	______________

Please list all hospitalizations and surgical procedures

Procedure	Date	Procedure	Date
_________________________	________	__________________________	________
_________________________	________	__________________________	________
_________________________	________	__________________________	________

FAMILY HISTORY

Specify any immediate family members (blood relatives) with the following condition:

	Yes	No	Relationship		Yes	No	Relationship
Heart disease	___	___	__________	Cancer, Breast	___	___	__________
High blood pressure	___	___	__________	Cancer, Ovarian	___	___	__________
Diabetes	___	___	__________	Cancer, Other	___	___	__________
Bleeding disorder	___	___	__________	Other	___	___	__________

SOCIAL HISTORY	Yes	No	How much
Do you smoke?	___	___	__________
Drink alcohol?	___	___	__________
Drink caffeinated drinks?	___	___	__________

NUTRITION

Current height _____________
Current weight _____________
Food allergies _____________

WOMEN: GYN HISTORY

Age of 1st menstrual period ____________
Date of last period _____________
Age when 1st child was born _____________
Number of pregnancies _____________
Number of live births _____________

Have you had a hysterectomy?_____ Removal of ovaries?_____
Have you taken birth control pills? ______________________
if yes from __________ to ____________
Have you taken hormone replacement_______________
if yes from ___________ to ______________

Reviewed by: ____________________

Review of Symptoms:
Do you currently have any of these symptoms:

		Yes	No		Yes	No
GENERAL	Fever	___	___	Chills	___	___
	Weight loss/gain	___	___	Fatigue	___	___
EYES	Eye pain/pressure	___	___	Double/blurred vision	___	___
ENT	Hearing loss	___	___	Ringing in ears	___	___
	Dizziness	___	___	Nose bleeds	___	___
	Difficulty swallowing	___	___	Sinus problems	___	___
	Hoarseness	___	___	Sore throat	___	___
CARDIAC	Chest pain	___	___	Ankle swelling	___	___
	Irregular heartbeat	___	___			
RESPIR.	Cough	___	___	Coughing blood	___	___
	Shortness of breath	___	___	Wheezing	___	___
GI	Abdominal pain	___	___	Nausea/vomiting	___	___
	Bloody stools	___	___	Diarrhea/constipation	___	___
GU	Frequent urination	___	___	Painful urination	___	___
	Blood in urine	___	___			
MUSC/SKEL	Muscle pain	___	___	Joint pain	___	___
	Bone pain	___	___	Osteoporosis	___	___
SKIN	Rash	___	___	Skin/hair changes	___	___
BREAST	Breast lumps	___	___	Nipple discharge	___	___
	Breast pain	___	___			
NEURO	Headache	___	___	Weakness	___	___
	Fainting	___	___	Numbness/tingling	___	___
PSYCH	Depression	___	___	Anxiety	___	___
HEME/LYMH	Swollen lymph nodes	___	___	Night sweats	___	___
				Bleeding problems	___	___
ALLERGY	Plant/animal allergy	___	___			

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Reviewed by: ______________________