Date:_____

Patient Questionnaire

Name: _____ DOB: _____ Phone#: _____

Address:_____ Email address:_____

How would you rate your health today? ◯ Very Good ◯ Good ◯ Fair ◯ Poor

What is your chief complaint today?_____

How long have you had this problem? _____

Are you currently taking any medication? (Please including birth control and over the counter medication _____

_____

_____

Do you have any allergies to any medication? _____

_____

_____

List all hospitalization / surgical procedures you have had since your last visit: _____

_____

_____

_____

Do you use:

Alcohol- Number of Years_____Number of days per week_____
Last Drink_____
Tobacco- Number of Years _____ Packs per Day _____
Illicit Drugs- Number of Years_____Number of days per week_____
Last Use_____

Females Only:
Last Menstrual Period: _____ Last Mammogram:_____
Last Pap Smear/Pelvic Exam:_____# Pregnancies._____

Office Use:

*Height:*_____ *Weight:*_____ *Waist*_____ *BMI*_____

Temp_____ Pulse_____ Respirations_____

Blood Pressure_____/_____ Pulse Ox_____

Blood Sugar_____