

PATIENT QUESTIONNAIRE-REPEAT EVALUATION

Patient Name: _____ Date of Birth: _____ Date of Exam: _____

List any problems you wish to discuss: _____

List any hospitalizations or surgeries in the past year: _____

List your current prescription medications, over the counter medications, herbal supplements and dosages:

Any medication or food allergies: _____

Do you smoke? _____ If so, how much? _____ Do you drink alcohol? _____ If so, how much? _____

Do you exercise? _____ Do you wear your seat belt? _____

Circle any of the following illnesses in a member of your immediate family (parent, brother, sister, child) **which have occurred since the time of your last exam:**

Cancer Heart attack High blood pressure Stroke Other _____

List any other doctors you have seen since your last visit: _____

Have you had any of the following symptoms in the past four months?

- | | | |
|---|--|--|
| <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Cough | <input type="checkbox"/> Yellow eyes/skin |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Difficulty urinating/incontinent |
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Backache | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Joint swelling or pain | <input type="checkbox"/> Excessive tiredness |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Chest pain/pressure/heaviness | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Change in eyesight | <input type="checkbox"/> Stomach/abdominal pain | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Depression/tearfulness |
| <input type="checkbox"/> Ears ringing/hearing loss | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Swelling of the ankles | <input type="checkbox"/> Constipation | <input type="checkbox"/> Extra heart beats or racing heart |
| <input type="checkbox"/> Black or bloody bowel movements | <input type="checkbox"/> Heartburn/indigestion | <input type="checkbox"/> Unusual bruising or bleeding |
| <input type="checkbox"/> Changes in wart/mole/skin growth | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Nasal congestion/drainage | <input type="checkbox"/> Difficulty swallowing/food sticking | <input type="checkbox"/> Sexual difficulties |
| | <input type="checkbox"/> Loss of strength or speech | <input type="checkbox"/> Leg cramps |
| | <input type="checkbox"/> Face pain | |
| | <input type="checkbox"/> Other _____ | |

Patient name: _____

Date of last colonoscopy or sigmoidoscopy: _____ Date of last rectal exam: _____

Date of last DEXA scan (bone density): _____

Have you ever had a blood transfusion? _____ If yes, when? _____

Do you have a living will or power of attorney? _____ Would you like information? _____

IMMUNIZATION RECORD:

Last tetanus vaccine: _____ Last hepatitis vaccine: _____ Shingles vaccine: _____

Last pneumonia vaccine: _____ Last flu vaccine: _____ Last MMR vaccine: _____

Gardasil vaccine: _____

Wellness practices: Skin exam: __Yes __No Sun protection: __Yes __No

Seat belt use __Yes __No Do you currently exercise? __Yes __No

Type of exercise _____ Frequency and duration of exercise _____

Hobbies/recreation: _____

Have you been hurt or threatened by someone within the past year? ____ If yes, please explain: _____

At any time, has someone hit, kicked or otherwise hurt or frightened you? _____

FOR WOMEN ONLY:

Date of last pap/pelvic? _____ Where was this performed? _____

Have you ever had an abnormal pap smear? _____ If yes, when? _____

Date of last period _____ Do you have irregular menstrual bleeding? _____

Do you have painful periods? _____ Do you have vaginal discharge? _____

Have you had bleeding after menopause? _____

Number of pregnancies _____ Number of live births _____ Number of living children _____

Hysterectomy? ____ If yes, when? _____ Why? _____

Are ovaries still present? _____

Date of last mammogram? _____ Do you perform monthly self-breast exams? _____

Do you have breast lumps/nipple discharge? _____