

# PATIENT QUESTIONNAIRE

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Family or Internal Medicine Physician: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## HISTORY OF PRESENT ILLNESS

Date symptoms began: \_\_\_\_\_

Describe present symptoms: \_\_\_\_\_

\_\_\_\_\_

Have you seen other physicians for this problem?  YES  NO

If yes, Whom have you seen:

Physician Name	Specialty	Phone Number

Have you had studies and/or labs performed to evaluate for this problem?  YES  NO

If yes, what studies have you had done?

Check Which Applies	Type of Study	Date Performed
<input type="checkbox"/> YES <input type="checkbox"/> NO	MRI/MRA - Body Part	
<input type="checkbox"/> YES <input type="checkbox"/> NO	CT Scans	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Echo Cardiogram	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Bronchoscopy	
<input type="checkbox"/> YES <input type="checkbox"/> NO	EMG/NCS (muscle/nerve conduction study)	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Lip Biopsy	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Muscle Biopsy	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Nerve Biopsy	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney Biopsy	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Liver Biopsy	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Skin Biopsy	
<input type="checkbox"/> YES <input type="checkbox"/> NO	Bone Marrow Biopsy	

### Have you or a blood relative had any of the following?

- |                        |                                                                     |                                                                                                        |
|------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| Diabetes Mellitus      | <input type="checkbox"/> You <input type="checkbox"/> Family Member | Psoriasis <input type="checkbox"/> You <input type="checkbox"/> Family Member                          |
| Gout                   | <input type="checkbox"/> You <input type="checkbox"/> Family Member | Rheumatoid Arthritis <input type="checkbox"/> You <input type="checkbox"/> Family Member               |
| Heart Disease          | <input type="checkbox"/> You <input type="checkbox"/> Family Member | Sarcoidosis <input type="checkbox"/> You <input type="checkbox"/> Family Member                        |
| High Blood Pressure    | <input type="checkbox"/> You <input type="checkbox"/> Family Member | Thyroid Disease/Goiter <input type="checkbox"/> You <input type="checkbox"/> Family Member             |
| Lupus                  | <input type="checkbox"/> You <input type="checkbox"/> Family Member | TIA/Stroke <input type="checkbox"/> You <input type="checkbox"/> Family Member                         |
| Migraines              | <input type="checkbox"/> You <input type="checkbox"/> Family Member | Tuberculosis <input type="checkbox"/> You <input type="checkbox"/> Family Member                       |
| Osteoarthritis         | <input type="checkbox"/> You <input type="checkbox"/> Family Member | Ulcerative Colitis/Crohn's Disease <input type="checkbox"/> You <input type="checkbox"/> Family Member |
| Polymyalgia Rheumatica | <input type="checkbox"/> You <input type="checkbox"/> Family Member | Uveitis or Iritis <input type="checkbox"/> You <input type="checkbox"/> Family Member                  |

**Continued from front page:**

Other family history: (Describe relationship to blood relative and disease) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAST MEDICAL HISTORY**

**Serious injuries:**

What Type	When	Outcome

**Any history of broken bones:**

Fracture Site	Age Occurred

**Surgical History:**

Surgical Procedure	Date Performed	Surgeon

**WOMAN ONLY**

Are you still having regular menstrual periods?  YES  NO

Hysterectomy?  YES  NO

Age of menopause onset? \_\_\_\_\_

Current hormone replacement?  YES  NO

Procedures	Date(s) of Last Testing	Physician
Pap Smear		
Mammogram		
Bone Mineral Density		

Number of Pregnancies	
	Live Births
	Miscarriages
	Abortions

**SOCIAL HISTORY**

**Occupation:** \_\_\_\_\_ **Marital Status:**  S  M  D  W **Age of Children:** \_\_\_\_\_

**Ethnicity:**  African-American  Asian  Caucasian  Hispanic  Native American/Alaskan Native  Other

**Smoking History:**  YES  NO Age Started: \_\_\_\_\_ Packs/day: \_\_\_\_\_ Quit? How Long? \_\_\_\_\_

**Alcohol use:**  YES  NO How much alcohol do you consume per day? \_\_\_\_\_

Any history of intravenous (injection) drug use?  YES  NO

**TRAVEL HISTORY**

**Immigrant:**  YES  No Country \_\_\_\_\_

**International Travel Past 3 years:**  YES  No Country \_\_\_\_\_

Any HIV/AIDS risk factors?  YES  NO (homosexuality, multiple sexual partners, history of sexually transmitted disease, unprotected intercourse with individuals at risk, injecting drug users, all recipients of blood, blood products or organ transplants between 1978 and 1985)

**Do You Exercise?**  YES  NO Frequency/week: \_\_\_\_\_ Type of exercise: \_\_\_\_\_

**Sleep Habits:** Hours of sleep at night: \_\_\_\_\_  
 Insomnia?  YES  NO If yes, describe: \_\_\_\_\_  
 Do you wake up feeling rested?  YES  NO  
 Have you had a sleep study?  YES  NO  
 Result \_\_\_\_\_

Do You Require use of any of the following:  Cane  Walker  Wheelchair  Scooter

### MEDICATIONS

**Medication Allergies:**

Medication	Reaction (i.e nausea, vomit, rash, headache, etc.)

**Present:** List any medications you are taking at this time. Include over the counter, vitamins, supplements

Name of Drug	Dosage (include strength and times per day)

**Past:** Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, the results of taking the medication, and list any reactions you may have had.

Drug - NSAIDS	Results of Medication	Reactions
Ansaid (Fubipohen)	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Arthrotec	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Aspirin	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Celebrex	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Indocin (Indometancin)	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Lodine (Etodolac)	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Mobic	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Motrin (Ibuprofen)	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Naproxen (Naprosyn/alleve)	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Oruvail (Ketoprofen)	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Oxaprozin (Daypro)	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Prioxicam (Feldene)	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Relafen (Nambumetone)	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Sulindac (Clinoril)	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Tolmentin (Tolectin)	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Voltaren (Diclofenac)	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	

Drug - Muscle Relaxers	Results of Medication	Reactions
Cyclobenzaprine (Flexeril)	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Robaxin	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Skelaxin	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Zanaflex	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Other:	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	

Drug - Other Pain Relievers	Results of Medication	Reactions
Ultram	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Ultracet	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Tylenol	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Other:	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	

Drug - Rheumatoid Arthritis	Results of Medication	Reaction
Arava	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Methotrexate	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Sulfasalazine (Azulfidine)	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Enbrel	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Humira	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Remicade	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Simponi	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Cimzia	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Orencia	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Rituxan	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Gold	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	

Drug - Other	Results of Medication	Reactions
Cytoxan (Cyclophosphamide)	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Imuran (Azathioprine)	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Plaquenil	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Prednisone / Medrol	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	

Drug	Results of Medication	Reactions
Neurontin	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Lyrica	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Cymbalta	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Savella	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	

Drug - Osteoporosis	Results of Medication	Reactions
Fosamax	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Actonel	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Boniva	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Reclast	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Forteo	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	
Evista	<input type="checkbox"/> Helped A Lot <input type="checkbox"/> Some <input type="checkbox"/> None	