Patient ID: _____

Patient Evaluation Questionnaire

Today's Date: ____/_____/_____

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____ _____ City: _____ _____ State: _____ Zip: _____

Birthdate: ___/___/_____ Age: _____ Gender: ☐ Male ☐ Female

Race *(check one)*

☐ White	☐ Black/African American	☐ Hispanic	☐ American Indian/Alaskan Native
☐ Asian	☐ Asian Indian	☐ Chinese	☐ Filipino
☐ Japanese	☐ Korean	☐ Vietnamese	☐ Native Hawaiian or other Pacific Island
☐ Samoan	☐ Guamanian or Chamorro	☐ Non-Specified	☐ Other: _____

Multi-Racial: *(check one)* ☐ Yes ☐ No ☐ Unknown

Ethnicity: *(check one)* ☐ African ☐ African American ☐ Chinese ☐ European ☐ Indian ☐ Japanese

☐ Korean ☐ Laotian ☐ Latino ☐ Middle Eastern ☐ Other ☐ South American ☐ Thai

Chief Complaint/Present Illness

Is today's visit related to: *(check one)*

☐ Work ☐ Car Accident ☐ Sports Injury ☐ Fall ☐ Home Injury ☐ Chronic Discomfort ☐ Other: _____

What is the primary symptom for which you are being seen?_____

What was the date when it started?_____

Where is it located?_____

How severe is it (from 1 to 10, with 1 being least and 10 being the worst possible pain)?_____

Grade 1 to 10 (10 being the worst possible) Average Daily Morning ___ Noon ___ Bedtime ___ Current _____

Do symptoms increase with specific activities or time of day? _____

What caused it or started it?_____

If pain, what is the character of it (sharp, dull, aching, pressure, cramping, burning, etc.)?_____

Does it move or radiate, and if so, to where?_____

What is the duration? How long does it last?_____

Is the condition: *(check one)* ☐ Getting Worse ☐ Staying Constant ☐ Coming and Going ☐ Improving

What is the frequency of it? How often does it come on?_____

What brings it on?_____

What makes it worse?_____

What makes it better?_____

Are there other symptoms associated with it? If so, describe them._____

_____

Does the condition interfere with: *(check one)* ☐ Sleep ☐ Work ☐ Daily Routine ☐ Other Activities: *(list)*_____

_____

What tests have you had to evaluate it? Give dates and where they were done._____

_____

What treatments have you had for it? Give dates and where they were done._____

_____

List other symptoms you are having. For each symptom, include date started, location, severity (1 to 10), cause or event that started it, where it moves, how long it lasts, how often it occurs, what brings it on, what makes it worse, what makes it better, symptoms related to it, tests done to evaluate it, treatments done._____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient ID: _____

Past Health

Previous medical illnesses and date when started:

Previous surgical procedures and date or age at surgery:

Do you have any current allergies? ☐ Yes (*Please list allergy and reaction)* ☐ No

_____

_____

Are you allergic to any medications? ☐ Yes (*Please list medication and reaction)* ☐ No

_____

_____

Medication/Supplement List

Medication or Supplement Name	Date Started	Date Stopped	Dosage	Frequency or Interval

Patient ID: _____

Family History

Please list any major diseases/conditions which run in your family (place check mark and list brother or sister under sibling.

	Father	Mother	Child/Sibling (Please circle)	Child/Sibling (Please circle)	Child/Sibling (Please circle)	Child/Sibling (Please circle)
Alive *(mark 'A' and list current age)*						
Deceased *(mark 'D' and list age at death and cause)*						
Heart Attack						
Congestive Heart Failure						
Peripheral Vascular Disease (Hardening of the Arteries)						
Stroke						
High Blood Pressure						
Diabetes *(list insulin-dependent or non-insulin dependent)*						
High Cholesterol or Triglycerides						
Obesity						
Cancer *(list type, i.e. breast, colon, lung, lymphoma, leukemia, etc.)*						
Emphysema/COPD						
Asthma						
Arthritis (unknown type)						
Osteoarthritis						
Rheumatoid Arthritis						
Lupus or "SLE"						
Ankylosing Spondylitis						
Muscle Disease *(list type)*						
Osteoporosis						
Parkinson's						

	Father	Mother	Child/Sibling (Please circle)	Child/Sibling (Please circle)	Child/Sibling (Please circle)	Child/Sibling (Please circle)
Alzheimer's						
Multiple Sclerosis						
Depression						
Alcohol Addiction						
Smoking Addiction						
Headache						
Glaucoma						
Other (specify)						

Personal and Social History

Marital Status: *(check one)* ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Live with:

Children *(list children and current ages)*:

Occupation(s) Past/Current:

Do you consume: *(check one and list the amount and length of time)*

☐ Alcohol Beer/Week_____ Hard Liquor/Week_____ Wine/Week _____ No. Yrs _____

☐ Caffeine Cups/Day (Coffee, Tea, Cola) _____ No. Yrs_____

☐ Tobacco Type _____ Number or Packs/Day _____ No. Yrs _____

☐ Former Smoker ☐ Never Smoked ☐ Desiring to Quit

☐ Recreational Drug use past/present *(list type, amount and length of time)* _____

Patient ID: _____

Review of Systems

General

___ Recent weight gain (amount _____)
___ Recent weight loss (amount _____)
___ Fatigue or weakness
___ Fever
___ Fainting
___ Other:

Integument

___ Changes to birthmark/moles
___ Rash
___ Persistent sores
___ Acne
___ Nail/Hair Changes
___ Other:

Lymphatic

___ Lumps or masses
___ Enlarged nodules
___ Other:

HEENT

___ Headaches/migraines
___ Eye pain
___ Blurred or double vision
___ Impaired vision
___ Loss of hearing/deafness
___ Ringing in ears
___ Discharge or ache in ear
___ Change in sense of smell
___ Nose bleeds or discharge from nose
___ Pain or obstruction in nose
___ Sore/bleeding gums
___ Mouth/throat sores
___ Dry mouth
___ Trouble swallowing
___ Loss of taste
___ Other:

Respiratory

___ Shortness of breath
___ Chest pain
___ Dry cough
___ cough with sputum production
___ Exposed to inhalants
___ Other:

Cardiovascular

___ Chest pain
___ Heart Murmur
___ Irregular heartbeats
___ Heart attack
___ Swelling in ankles
___ High Blood Pressure
___ Pain in legs with walking/climbing stairs
___ Varicose veins
___ Other:

Gastrointestinal

___ Abdominal pain
___ Nausea/vomiting
___ Bloating/Gas
___ Heartburn *or* indigestion
___ Jaundice
___ Crohn's disease or ulcerative colitis
___ Constipation
___ Diarrhea
___ Hemorrhoids
___ Change in appetite
___ Bloody/black stools
___ Other:

Genitourinary

___ Incontinence
___ Blood or pus in urine
___ Increased urination day/night
___ Painful urination
___ Kidney or bladder infections
___ Kidney stones
___ Discharge from penis *or* vagina
___ Painful intercourse *or* impotence
___ Other:

Neurologic

___ Numbness *or* tingling
___ Weakness
___ Dizziness *or* vertigo
___ Seizures *or* convulsions
___ Blackout spells
___ Loss of balance
___ Tremors
___ Loss of memory
___ Difficult speech
___ Loss of coordination
___ Change in grip/hand strength
___ Other:

Rheumatologic

___ Joint pain
___ Joint swelling
___ Joint stiffness
___ Muscle pain
___ Muscle weakness
___ Muscle cramps
___ Muscle spasms/twitching
___ Other:

Hematologic

___ Low blood (Anemia)
___ Easy/prolonged bleeding
___ Easy or lasting bruising
___ Blood disorder (please list):
___ Other:

Endocrinologic

___ Diabetes
___ Pituitary disorders
___ Thyroid disorders
___ Adrenal disorders
___ Sensitivity to heat or cold
___ Other: