



5319 Parkshire Way
 North Charleston, S.C 29418
 (843) 767-2121
 Fax: (843) 767-2102

PATIENT QUESTIONNAIRE

REASON FOR VISIT _____

PAST MEDICAL & FAMILY HISTORY Please check (✓) if you (SELF) or any blood relative (FAM) had any of the following conditions.

	SELF	FAM		SELF	FAM
1. HEADACHES / MIGRAINE	<input type="checkbox"/>	<input type="checkbox"/>	15. BLOOD TRANSFUSIONS	<input type="checkbox"/>	<input type="checkbox"/>
2. HEART / VASCULAR DISEASE RHEUMATIC DIS	<input type="checkbox"/>	<input type="checkbox"/>	16. ANEMIA / BLOOD DISORDER	<input type="checkbox"/>	<input type="checkbox"/>
3. HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	17. VARICOSE VEINS / PHLEBITIS	<input type="checkbox"/>	<input type="checkbox"/>
4. HIGH CHOLESTEROL	<input type="checkbox"/>	<input type="checkbox"/>	18. SKIN DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
5. RESPIRATORY DISEASE PULMONARY (LUNG)	<input type="checkbox"/>	<input type="checkbox"/>	19. DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
6. BREAST DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	20. THYROID DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
7. JAUNDICE / HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	21. CANCER (TYPE)	<input type="checkbox"/>	<input type="checkbox"/>
9. HIATAL HERNIA (REFLUX)	<input type="checkbox"/>	<input type="checkbox"/>	(TYPE)	<input type="checkbox"/>	<input type="checkbox"/>
10. PEPTIC ULCER (STOMACH)	<input type="checkbox"/>	<input type="checkbox"/>	22. EPILEPSY / NEUROLOGICAL DIS.	<input type="checkbox"/>	<input type="checkbox"/>
11. BOWEL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	23. ARTHRITIS - JOINT PAIN	<input type="checkbox"/>	<input type="checkbox"/>
12. KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	24. OSTEOPOROSIS	<input type="checkbox"/>	<input type="checkbox"/>
13. URINARY INCONTINENCE	<input type="checkbox"/>	<input type="checkbox"/>	(FRAGILE BONES)	<input type="checkbox"/>	<input type="checkbox"/>
14. URINARY INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>	25. ANXIETY / DEPRESSION	<input type="checkbox"/>	<input type="checkbox"/>
			26. SLEEP PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>

HOSPITAL ADMISSIONS List those operations & serious illness which required hospitalization (excluding pregnancy)

YEAR	REASON FOR ADMISSION / HOSPITALIZATION	YEAR	REASON FOR ADMISSION / HOSPITALIZATION

MEDICATIONS List all medications you are currently taking (dosage-frequency) - include over the counter drugs, vitamins and herbal medications.

		Drug Allergies

DIET

How would you describe your diet? _____
 Would you like to see a nutritionist? _____

EXERCISE

Do you exercise? ___ Regularly ___ Occasionally ___ Not at all. What type of exercise do you participate in? _____
 Do you have issues you would like to address regarding exercise or an exercise program? _____

MENSTRUAL HISTORY Age at first period? _____ If Menstruating - date of last period (1st day) _____

Period Interval (1st day to 1st day)	Number of days?	Duration of Bleeding?	Cramps?	Y	N	Mild	Severe	Mod.	Always Present	Medications for cramps?	Y	N
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

How many periods in the last year? _____ Bleeding (spotting) between periods? Y N

VAGINAL INFECTIONS - History of YEAST TRICHOMONAS CHLAMYDIA HERPES GONORRHEA BACTERIAL VAGINOSIS

PAP TEST Date of last test _____ NORMAL ABNORMAL MAMMOGRAM Date of last test _____ NORMAL ABNORMAL

CONTRACEPTIVE HISTORY Current Method _____ IF PILL - BRAND _____ PAST METHODS _____

OBSTETRICAL HISTORY

HISTORY -Number of PREGNANCIES _____					PREMATURE BABIES _____					MISCARRIAGES _____					ABORTIONS _____					LIVING CHILDREN _____															
BORN YEARS / MOS.	WEEKS PREG.	WT.	SEX	TYPE OF DELIVERY	REMARKS	BORN YEARS / MOS.	WEEKS PREG.	WT.	SEX	TYPE OF DELIVERY	REMARKS	BORN YEARS / MOS.	WEEKS PREG.	WT.	SEX	TYPE OF DELIVERY	REMARKS	BORN YEARS / MOS.	WEEKS PREG.	WT.	SEX	TYPE OF DELIVERY	REMARKS												
1.						4.						2.						5.						3.						6.					
2.						5.						3.						6.																	
3.						6.																													

MENSTRUAL HISTORY If applicable - HOT FLASHES Y N TREATMENT _____

SEXUAL HISTORY SATISFACTORY UNCOMFORTABLE WISH TO DISCUSS _____

SOCIAL HISTORY Smoking - Cig./Day _____ # Years _____ Alcohol - Oz./Week _____ Coffee - Cups/Day _____ Street Drugs _____