



PATIENT QUESTIONNAIRE

Complete All Questions – Please Print

Date: _____

Patient Name: _____

Date of Birth: _____ SSN: _____

Address: _____ City: _____ State / Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: S M W D Spouse Name: _____ DOB: _____

Occupation: _____ Religion: _____

Ethnicity: Non-Hispanic/Latino Hispanic/Latino

Gender: Male Female

Race: White Asian American Indian or Alaska Native Black or African American
 Native Hawaiian or Other Pacific Islander Other _____

Language Preference: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Primary Care Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

Pharmacy: _____ Phone Number: _____

Preferred Blood Work Lab: _____ Phone Number: _____

Do you have an Advanced Director or Living Will for Health Care? Yes No (if yes, please provide copy)

Primary Insurance:

Insurance Name: _____ Policy #: _____

Insurance Phone: _____

Secondary Insurance:

Insurance Name: _____ Policy #: _____

Insurance Phone: _____



Patient Name: _____

Reason for today's visit: _____

Have you ever had or been diagnosed with:

- | | | | |
|------------------------|--|---------------------|--|
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Facial Weakness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Balance disturbance | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding tendencies | <input type="checkbox"/> Yes <input type="checkbox"/> No | High cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood clots | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood transfusion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypertension | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blurred vision | <input type="checkbox"/> Yes <input type="checkbox"/> No | Irregular pulse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficulty with speech | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Cancer Yes No Type: _____

Kidney Disease Yes No Explain: _____

Liver Disease Yes No Explain: _____

Other: _____

Surgical History (please list all prior surgeries):

<u>Date</u>	<u>Surgery</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



Patient Name: _____

Personal History:

Do you have children: Yes No If yes, how many: _____
Problems with anesthesia: Yes No
Are you claustrophobic: Yes No

Tobacco History:

Current every day smoker # per day: _____ For how long: _____
 Current occasional smoker # per day: _____
 Former smoker When did you quit: _____
 Never smoked

Alcohol History:

Consume alcohol daily How much per day: _____
 Consume alcohol socially How frequently: _____
 Never consume alcohol

Drug Use History:

Recreational drug use: Yes No

Allergies:

Check here if you have no known allergies.
Latex allergy: Yes No
Iodine / Seafood allergy: Yes No
Medication(s) and reaction: _____

Mammography:

If you are a woman (40 - 69 years of age), did you have a mammogram within the past year?
 Yes, approximate date: _____ No Unsure



Patient Name: _____

Medications:

Please list all prescription medications, herbal supplements, and over the counter medications – use an additional sheet of paper if necessary.

<u>Medication</u>	<u>Dose</u>	<u>Frequency</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History:

		<u>Relation</u>	<u>Type (if known)</u>
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Strokes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Brain Aneurysms	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

The above information is accurate to the best of my knowledge.

Patient Signature

Date

I have reviewed the information with the patient.

Signature of Individual Reviewing Form

Date



PATIENT PRIVACY FORM

Patient Name: _____

DOB: _____

As our patient, we may need to communicate with you when you are not in the practice. To assure your privacy, we would like you to indicate your preferred method for us to communicate medical information to you and/or to others involved in your care. Please note that an “appointment reminder” is not classified as medical information.

Please indicate your communication preferences below:

I give permission to leave medical information pertaining to me, my dependent or child, at the numbers listed below:

Contact Method	Yes / No	Phone Number
Home	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Answering Machine	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Work Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cell Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pager	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Without specific permission, we will not release any medical information to anyone other than you. In some cases you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner, etc.).

Do not release medical information to anyone other than myself.

I give permission to release medical information pertaining to me to the individual(s) listed below:

Name	Relationship	Phone Number

I assume responsibility to inform the practice of changes in my phone number(s) or my preferences or to revoke this specific medical information authorization at any time.

Signature of Patient or Legal Representative

Date

Signer’s Printed Name