

Clinical Questionnaire

Please complete this form as accurately as possible:

Name: _____ Age: ___ Gender: ___

Referring Physician: _____

Other Physician currently treating you (& specialty): _____

Reason for visit: _____

Duration of illness: _____

PAST MEDICAL HISTORY (Current or past illnesses)

Heart

High Blood Pressure Yes No

High Cholesterol or lipids Yes No

Coronary Artery Disease Yes No

Heart Attack Yes No

Irregular Heart Beat Yes No

Other _____

Lung

COPD (Emphysema/Chronic Bronchitis) Yes No

Asthma Yes No

Pneumonia Yes No

Other _____

Gastrointestinal

Reflux Disease (or Hiatal Hernia) Yes No

Peptic Ulcer Disease Yes No

Gall Bladder Disease Yes No

Hepatitis B or C Yes No

Other _____

Endocrine

Diabetes Mellitus Yes No

Thyroid disease Yes No

Other _____

Cancer

Ever diagnosed with Cancer? Yes No

Year, type & treatment: _____

Blood Disorders

Anemia Yes No

Bleeding disorders/Excessive bleeding Yes No

Other _____

Musculoskeletal System

Osteoarthritis Yes No

Gout Yes No

Other _____

Peripheral Vascular Disease

Deep Vein Thrombosis (DVT) Yes No

(Blood Clots)

Pulmonary Embolism (PE) Yes No

Varicose Veins Yes No

Arterial Vascular Disease Yes No

Other _____

Psychological Disorders

Depression Yes No

Anxiety Yes No

Other _____

Neurologic Disorders

Stroke Yes No

Alzheimer's Yes No

Other _____

Other illnesses not listed above: 1. _____

2. _____ 3. _____

PAST SURGICAL HISTORY

Please list all prior surgical procedures: None

Type of Surgery _____ Year _____

Type of Surgery _____ Year _____

Type of Surgery _____ Year _____

Type of Surgery _____ Year _____

Have you had a complication after surgery? Yes No

If yes, please explain: _____

ALLERGY TO MEDICATIONS

None

Please list any medication to which you are allergic to:

1. _____ 2. _____

3. _____ 4. _____

CURRENT MEDICATIONS

None

Please list all medications that you are currently using:

	Medications	Dose	Times/ day
1.			
2.			
3.			
4.			

FAMILY HISTORY

Has any family member had any of the following:

Difficulty with Anesthesia: Yes No

Excessive bleeding after a procedure: Yes No

If yes, please explain: _____

SOCIAL HISTORY

Tobacco use: Current Past None

If yes, average use: ___ packets/day; duration: ___ years

Quit (if applicable) ___ years ago

Alcohol use: Current Past None

If yes, average use: ___ drinks/week; Type: _____

Quit (if applicable) ___ years ago

Occupation: _____ Employer _____

REVIEW OF SYSTEMS Please circle any of the following symptoms you might have experienced over the past 3 months:

Constitutional: Fever, Chills, Tiredness, Weight loss >10%

Psychologic: Anxiety, Depression, Difficulty Sleeping

Neurologic: Dizziness, Hand/Foot Tingling or Numbness

Eyes: Blurry vision, Eye pain

Ear/Nose/Throat: Ear ache, Nose Bleed, Change in Voice

Heart: Chest Pain, Shortness of Breath, Palpitation

Lungs: Cough, Sputum, Shortness of Breath, Wheezing

Gastrointestinal: Abdominal pain, Heartburn, Nausea, Vomiting, Bloating, Diarrhea, Constipation, Blood from Rectum

Genitourinary: Burning with Urination, Increased Frequency, Difficulty Controlling Bladder, Penile or Vaginal Discharge

Musculoskeletal: Pain in Joints, Muscles, or Bones

Skin: Skin Rash, Excessive Itching, Eczema, Dry skin

Hematologic: Excessive Bruising, Swollen Glands

Patient Signature: _____ Date: ___ / ___ / ___

Surgeon's Comments: _____

Surgeon's Signature: _____ Date: ___ / ___ / ___