BAPTIST PRIMARY CARE
ST. JOHNS FOREST

PATIEN T QUESTIONNAIRE

Name: ____ Date of birth: ____________ Today's date: _____________

Note: Medicare does not pay for preventative services. If you are covered under Medicare and do not have supplemental insurance to cover this charge, you may be responsible for the charges incurred for your preventative visit.

Do you have any drug allergies? □ Yes (list below and do include the reaction you had to the medication) □ No

____

Medications: (Name, strength, how often per day): Aspirin Daily Multivitamin Calcium

____

____

____

____

Local Pharmacy: ____

Mail Order Pharmacy:____

Medical History:

□ Diabetes: ______________________________ □ Lung Disease: ________________________________

□ Heart Disease: __________________________ □ Asthma: _____________________________________

□ Hypertension: ___________________________ □ High Cholesterol: ______________________________

□ Cancer: (Type): __________________________ □ Seizures: ____________________________________

□ Stroke: _________________________________ □ Depression/Anxiety: ___________________________

□ Alcohol/Drug Use: ________________________ □ Skin Disorders: _______________________________

□ Other (specify) ____

Obstetrical history No. of Pregnancies: ________ No. of deliveries vaginal ________ c-section ______________

Family History (Please list family member affected)

□ Diabetes: ______________________________ □ Lung Disease: ________________________________

□ Heart Disease: __________________________ □ Asthma: _____________________________________

□ Hypertension: ___________________________ □ High Cholesterol: ______________________________

□ Cancer: (Type): __________________________ □ Seizures: ____________________________________

□ Stroke: _________________________________ □ Depression/Anxiety: ___________________________

□ Alcohol/Drug Use: ________________________ □ Skin Disorders: _______________________________

□ Other (specify) ____

Surgical History: (Please list date of surgery)

□ appendectomy ___________ □ gallbladder removal __________ □ tonsil and adenoidectomy ________

□ hemorrhoid removal________ □ hernia repair ________________ □ blood transfusion: _____________

□ bladder suspension ________ □ colon resection: _____________ □ breast surgery: ________________

□ other: ____

Social History

Marital status: □ single □ married □ separated □ divorced □ widowed **Occupation:**___________________________________

How much **tobacco** do you smoke or chew per day? ____

How much **alcohol** do you consume per week? ____

How much **caffeine** do you consume per day? (coffee, tea, chocolate, soda) ____

What do you do for **exercise**? ____

Immunizations (please list date)

Tetanus ___________________ Pneumovax ______________ Influenza ______________

Hepatitis A series ____________ Hepatitis B Series _________ Guardasil ______________

Meningitis __________________ MMR ___________________ Varicella _______________

Preventative Health

□ Last Colonoscopy (date, location, findings) ____

□ Last Mammogram (date and location) ____ □ Breast Implants present

□ Last Bone Density (date and location) ____

□ Last Pap smear (date) ________________ □ any abnormal paps? ________ Name of GYN: _________________________

What method of birth control do you use?

□ Not applicable □ Pill □ Patch □ Vaginal ring □ Vasectomy □ Tubal ligation (year) __________

Are you having regular periods?

□ Yes First day of your last period ________________ □ No due to □Menopause (year) ______ □ Hysterectomy (year) ________

Are you experiencing any of the following symptoms in relation to your main concern?
(Answer "yes" by circling the appropriate symptom.)

Constitutional symptoms: fever, chills, weight loss, extreme fatigue

Eyes: double vision, sudden loss of vision, itching, blurred vision

Ears, nose, mouth and throat: sore throat, runny nose, ear pain, vertigo, sneezing, nasal congestion, nose bleeds

Cardiovascular: chest pain, palpitations, shortness of breath when laying flat, leg swelling

Respiratory: cough, wheezing, shortness of breath;

Gastrointestinal: vomiting, abdominal pain, constipation, diarrhea, blood in stools

Genitourinary: irregular menses, vaginal bleeding, vaginal discharge, frequent or painful urination, bloody urine, impotence,

Skin: rash, changing mole, itching,

Neurological: persistent weakness, numbness on one side of the body, falling, seizures

Musculoskeletal: joint pain, muscle weakness, back pain

Psychiatric: depression, anxiety, suicidal thoughts, difficulty falling asleep or maintaining sleep, tension

Endocrine: excessive thirst, cold or heat intolerance, breast mass, nipple discharge, excessive sweating,

Hematologic: enlarged lymph nodes, anemia, easy bleeding

Allergic: hay fever, hives

_______________________________________ ___________________

Patient Signature Date