Patient Questionnaire

BAPTIST Primary Care
Changing Health Care for Good.®

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 ☐ aginal _____ ☐ 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: _____

Patient Name: _____ MRN: _____

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, 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

_____ _____

Physician Signature Date

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