PATIENT QUESTIONAIRE

NAME: _____
PHONE: (___) ___ - _____

Reason for visit: _____

_____

Do you have any allergies? **Yes (please list below)** **No**

_____

Are you on medication? **Yes (please list below)** **No**

_____

_____

Are you pregnant? **Yes** **No** **Not applicable**

Please check if you do any of the following:

Smoke

Drink (Alcohol)

Drugs

Do you have a family history of heart disease? **Yes** **No**

Cancer? **Yes** **No**

Do You Need Pain Medications/ Controlled Substances **Yes** **No**

Consent for FLU/ Pneumonia shot **Yes** **No**

Review of systems:. General: No fever, chills, or weight change. Eyes: No blurred or double vision. Head: No headaches or migraines. Chest: No cough or shortness of breath. Heart: No chest pain, No palpitations Gastrointestinal: No abdominal pain, nausea, diarrhea, or constipation. GU: No kidney stones, urinary tract infections, or other urinary tract problems. Musculoskeletal: No joint or back pain or muscle problems. Skin: No rashes or other skin complaints. Neurologic: No weakness, no stroke, no seizures, no numbness or tingling. Psychiatric: No anxiety or depression. Endocrine: No excessive thirst or excessive heat or cold. Immunologic: No tuberculosis, hepatitis, or recurrent infections. Hematologic: No anemia or easy bleeding.
check here if above negative ☐

Signature _____