Complete Medical Questionnaire

Name: ______________________________________ **Date:** _________________________

The following list of symptoms is a tool to help your doctor identify and diagnose possible problems.

Please list the most important symptoms, concerns or questions you have today.

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1. In the first column below, **CIRCLE** any symptoms you have (see example).
2. In the next two columns, **CHECK** how concerned you are and fill in the approximate date the symptoms started.
3. In the last column, **DESCRIBE** the symptoms briefly**.**
NOTE - If **NO SYMPTOMS** on a given line are present, **LEAVE THE ENTIRE LINE BLANK.**

1. CIRCLE All Current/Recent Symptoms	**2. Level of Concern**	**2. Date of Onset**	**3. Description of Symptoms**
EXAMPLE:	Low Med High	mm/yy	
◆ pain / swelling / (stiffness /) weakness	☐ ☑ ☐	07/10	Right shoulder, getting worse
Head and Neck:			
◆ headaches	☐ ☐ ☐		
◆ hearing problems /ear ringing or pain	☐ ☐ ☐		
◆ vision problems / eye pain or redness	☐ ☐ ☐		
◆ throat pain / hoarseness / swallowing	☐ ☐ ☐		
◆ pain in teeth / gums / mouth	☐ ☐ ☐		
◆ nose or sinus problems	☐ ☐ ☐		
◆ neck pain / lumps	☐ ☐ ☐		
Chest:			
◆ shortness of breath	☐ ☐ ☐		
◆ chest pain	☐ ☐ ☐		
◆ coughing / blood in sputum / wheezing	☐ ☐ ☐		
Heart/Blood Vessels:			
◆ chest tightness or pressure with exertion	☐ ☐ ☐		
◆ ankle or leg swelling / varicose veins	☐ ☐ ☐		
◆ heart racing / skipping beats	☐ ☐ ☐		
◆ poor circulation hands / feet	☐ ☐ ☐		
Stomach/Bowels:			
◆ heartburn / indigestion / nausea / vomiting	☐ ☐ ☐		
◆ stomach pain / spasm	☐ ☐ ☐		
◆ constipation / diarrhea / leakage of stool	☐ ☐ ☐		
◆ blood / mucus in stools	☐ ☐ ☐		
◆ hemorrhoids / anal pain or bumps	☐ ☐ ☐		
◆ binge eating / loss of appetite	☐ ☐ ☐		
◆ weight gain/loss > 10 lb (past 6 months)	☐ ☐ ☐		
Kidneys/Bladder:			
◆ painful / frequent / urgent urination	☐ ☐ ☐		
◆ blood in urine	☐ ☐ ☐		
◆ frequent bladder infections	☐ ☐ ☐		
◆ leakage of urine (incontinence)	☐ ☐ ☐		
◆ up at night to urinate more than once	☐ ☐ ☐		
◆ difficulty starting / slow stream / dribbling	☐ ☐ ☐		
Skin:			
◆ dry / itchy skin	☐ ☐ ☐		
◆ acne / hives / rash	☐ ☐ ☐		
◆ changing moles / lumps / growths	☐ ☐ ☐		
◆ sores that won't heal	☐ ☐ ☐		

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1. **CIRCLE** All Current/Recent Symptoms	2. Level of Concern			Date of Onset	3. Description of Symptoms
Muscles, Joints, Bones:	Low	Med	High	mm/yy	
• pain / swelling	☐	☐	☐		
• weakness / stiffness	☐	☐	☐		
• trouble getting up from a chair	☐	☐	☐		
Nervous System:					
• fainting / blackouts / dizziness	☐	☐	☐		
• numbness / tingling (pins and needles)	☐	☐	☐		
• poor memory / concentration	☐	☐	☐		
• poor balance / coordination	☐	☐	☐		
• seizures / tremors	☐	☐	☐		
• decreased ability to write / slurred speech	☐	☐	☐		
Sexual/Reproductive Health:					
• loss of interest in sex	☐	☐	☐		
• sexually active – now / in the past	☐	☐	☐		
• same gender sex partner – now / in the past	☐	☐	☐		
• unable to achieve orgasm	☐	☐	☐		
• genital sores, lumps, warts / past STDs	☐	☐	☐		
• infertility	☐	☐	☐		
• contraception – type used:	☐	☐	☐		
Men:					
• inability to achieve / maintain erection	☐	☐	☐		
• discharge from penis	☐	☐	☐		
• testicular pain / lump / swelling	☐	☐	☐		
Women:					
• heavy / irregular / painful / absent periods	☐	☐	☐		
• PMS (bloating, moody, breast pain, etc)	☐	☐	☐		
• vaginal discharge / pain / itch / dryness	☐	☐	☐		
• pelvic pain or bleeding with intercourse	☐	☐	☐		
• lack of lubrication during intercourse	☐	☐	☐		
• hot flashes	☐	☐	☐		
• breast pain or lump / nipple discharge	☐	☐	☐		
Emotional health:					
• excessive worry / anxiety / anger	☐	☐	☐		
• unable to relax / tense / fidgety	☐	☐	☐		
• depression / sadness / tearfulness	☐	☐	☐		
• poor concentration / racing thoughts	☐	☐	☐		
• trouble getting to sleep / staying asleep	☐	☐	☐		
• not rested after sleep / snoring	☐	☐	☐		
• low energy / decreased motivation	☐	☐	☐		
• low self-esteem	☐	☐	☐		
• ongoing stresses / major losses	☐	☐	☐		
• suicidal thoughts or feelings	☐	☐	☐		
Social Health:					
• work or financial problems	☐	☐	☐		
• relationship problems or issues	☐	☐	☐		
• no one to discuss things with	☐	☐	☐		
• exposure to toxic substances	☐	☐	☐		
• worries regarding family or friends	☐	☐	☐		
• emotional / physical / sexual abuse	☐	☐	☐		
• addictions (drugs, sex, alcohol, gambling)	☐	☐	☐		

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Preventive Health Questionnaire

Name: ___________________________ Birth date: ______________ Date: ____________

RISK FACTORS

Nonchangeable:
Gender: ☐Male ☐Female Age: _____ Race:____________________________

Family History (parents or siblings): ☐Heart Attack ____ (age), ☐Diabetes ____ (age), ☐Depression
☐Mental Illness, ☐Osteoporosis, ☐Cancer (indicate type)___________________________

Medical History: ☐High Blood Pressure, ☐Diabetes, ☐High Cholesterol, ☐Angina, ☐Stroke
☐Kidney Disease, ☐Lung Disease, ☐Osteoarthritis, ☐Rheumatoid Arthritis, ☐Depression
Women Only: ☐Onset of periods before age 12, ☐Periods stopped after age 45 ☐or after age 52
☐No children by birth, ☐First child after age 30, ☐Total breastfeeding time less than 1 year
☐ Use of Hormone Therapy over 5 years, ☐Prolonged use of Prednisone

Changeable:

Diet: ☐Less than 3 servings/day of vegetables, ☐Less than 3 servings/day of fruit
☐More than 4 servings/day of animal fat, ☐One or more servings/day of red meat
☐Large amount of added salt, ☐Low calcium intake

Beverages: ☐More than 2 caffeine drinks/day, ☐More than 1 alcohol drink/day

Weight: ______ Height: ______ Maximum weight ever: ______ Desired Wt: ______

Exercise: ☐Moderate activity for 20 min less than 4 times/week

Smoking: ☐Any amount

Psychological: ☐Significant amount of stress, ☐Tendency to repress emotions

WELLNESS GOALS
What areas of your life would you like to make changes in?

____

____

____

What changes have you made / are you making so far?

____

____

____

What are some of the barriers preventing you from improving your health and wellness?

____

____

How confident are you in your ability to improve your health and wellness?
☐Very confident ☐Somewhat confident ☐Moderately confident ☐Slightly confident ☐Not confident

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Thank you for taking the time to fill out this questionnaire.
Your responses will greatly aid your healthcare team in determining what areas of your health need further investigation and treatment.