PRIMARY CARE SPECIALISTS, INC.

MEDICAL QUESTIONNAIRE - ADULT

Patient's Name ____

Date of birth ________________Age__________ Acc#___________________

Date of Visit_________________

PAST HISTORY:

1. Do you now have or did you ever have any of these conditions? Check the appropriate box.

[ ] measles	[ ] heart trouble	[ ] kidney trouble	[ ] tuberculosis
[ ] mumps	[ ] heart attack	[ ] diabetes	[ ] high blood pressure
[ ] chicken pox	[ ] pneumonia	[ ] liver trouble	[ ] high cholesterol
[ ] cancer	[ ] sickle cell	[ ] asthma	[ ] nervous breakdown
[ ] glaucoma	[ ] seizures	[ ] stroke	[ ] HIV / AIDS
[ ] hepatitis	[ ] anemia	[ ] ______________________________________	

2. List any hospitalizations, surgeries or serious injuries. Include the approximate dates.

____

____

____

FAMILY HISTORY:

1. Is your mother living?____ If not, what did she die from? _________________
2. Is your father living? ____ If not, what did he die from? __________________
3. How many brothers? Living _____ Deceased _____ Sisters? Living _____ Deceased _____
4. How many children? Boys, Living _____ Deceased _____ Girls, Living _____ Deceased _____
5. Does any one in your family (mother, father, siblings, aunts, uncles, grandparents, etc.) have any of these following conditions? Check the appropriate box.

[ ] tuberculosis	[ ] heart disease	[ ] diabetes	[ ] hypertension
[ ] stroke	[ ] kidney disease	[ ] sickle cell	[ ] cancer____________
[ ] arthritis	[ ] liver disease	[ ] anemia	[ ] seizures
[ ] stomach/bowel disease	[ ] AIDS/HIV	[ ] migraines	[ ] other_____________

ALLERGIES:

Are you allergic to any medications? ____ If so, what? ____

MEDICATIONS:

List all medications and their doses (if known) ?____

____

____

____

If you brought your medications with you, show them to the nurse at the time of the interview.

HABITS:

1. How much alcohol, wine or beer do you drink per day, week, month, etc.________
   ____
2. Do you smoke? ________If so, how much a day? _____________Number of years?_______

3. Do you use recreational or illicit drugs? ______If so, what kind?________________________

SOCIAL HISTORY:
1. How many years of school did you complete? ____
2. What is your occupation? ____
3. Marital status? [ ] married [ ] single [ ] separated [ ] divorced [ ] widowed
4. What type of home do you live in? [ ] house [ ] apartment [ ] condo [ ] assisted living
   [ ] elderly adult home [ ] nursing home [ ] Other_________________________________
4. Who lives in the home with you? ____

REVIEW OF SYSTEMS:
If you have any of the following problems, please check the appropriate box.

HEENT
[ ] Decreased hearing
[ ] Failing or blurred vision
[ ] Sinus trouble
[ ] Hay fever / allergies

CARDIOPULMONARY
[ ] Palpitations / Irregular heart beat
[ ] Chronic cough / bronchitis
[ ] Asthma / wheezing
[ ] Shortness of breath
[ ] Chest pain
[ ] Heart murmur

MUSCULOSKELETAL
[ ] Swollen feet / legs
[ ] Varicose veins / blood clots
[ ] Arthritis / Gout
[ ] Back pain

OTHER
[ ] ____________________________

URINARY
[ ] Frequent urination
[ ] Frequent urine infections
[ ] Painful urination
[ ] Blood in urine
[ ] Night time urination
[ ] Poor control of urination
[ ] Kidney stones

NEUROLOGICAL
[ ] Headaches - frequent
[ ] Seizures / convulsions
[ ] Stroke
[ ] Tremor / shaking
[ ] Muscle weakness
[ ] Numbness / tingling

PSYCHIATRIC
[ ] Sleeping difficulty
[ ] Nervousness
[ ] Depression

GASTROINTESTINAL
[ ] Loss of appetite
[ ] Difficulty swallowing
[ ] Indigestion / heartburn
[ ] Peptic ulcers
[ ] Stomach pain
[ ] Constipation
[ ] Bloody or black stools
[ ] Hemorrhoids
[ ] Gallstones

SKIN
[ ] Hives / Itching
[ ] Rashes
[ ] Psoriasis / eczema

GENERAL
[ ] Tiredness / fatigue
[ ] Weight loss
[ ] Dizzy spells
[ ] Fainting spells

FEMALES ONLY - Menstrual History
1. When was your last menstrual period? _______________ Age when menses began ? ______________
2. Are your periods regular? ____ Are they heavy, moderate or light? ____________
3. Do you have severe pain or cramps with your menses? _______ Any abnormal bleeding?__________
4. How long does your period last? _________ How many days from one period to the next?_________
5. Any pain or bleeding following sex? _________ Do you have hot flashes?_______________________
6. Number of pregnancies? _____ Live births? ______ Miscarriages? _____ Induced abortions? ______
7. What type of birth control do you use? __________________
   If you use the pill, what is the name of it? _________________
8. When was your pap smear? _________________________ Mammogram? _______________________