

DEKALB SURGICAL ASSOCIATES PATIENT QUESTIONNAIRE

Name _____ Age _____ Today's Date _____

Reason for your visit: _____

PLEASE CHECK ANY OF THE FOLLOWING WHICH MAY APPLY TO YOU

High blood pressure **Prior heart attack** **Heart failure** **Chronic lung disease** **Diabetes** **on pills** **on Insulin**

General: Your weight? _____ Unintended weight loss or gain , fatigue , fevers / chills, sweats , heat intolerance , insomnia

- | | | | | | |
|--|--|--|--|--|--|
| <p>Eyes:</p> <input type="checkbox"/> Loss of vision
<input type="checkbox"/> Cataracts
<input type="checkbox"/> Cataract surgery
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Intolerance of Bright lights | <p>Gastrointestinal:</p> <input type="checkbox"/> Ulcers
<input type="checkbox"/> Acid reflux / heartburn
<input type="checkbox"/> Nausea,
<input type="checkbox"/> Vomiting
<input type="checkbox"/> Gallstones
<input type="checkbox"/> Constipation
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Blood in stool
<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Chronic
<input type="checkbox"/> Acute/recent
<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Cirrhosis
Date of last colonoscopy _____ | <p>Musculoskeletal:</p> <input type="checkbox"/> Arthritis in
<input type="checkbox"/> Knees
<input type="checkbox"/> Hips
<input type="checkbox"/> Hands
<input type="checkbox"/> _____
<input type="checkbox"/> Hip replacement
<input type="checkbox"/> Knee replacement
<input type="checkbox"/> Gout
<input type="checkbox"/> Osteoporosis | <p>Neurologic:</p> <input type="checkbox"/> Epilepsy / seizure Disorder
<input type="checkbox"/> Stroke (year _____),
<input type="checkbox"/> Headaches
<input type="checkbox"/> Numbness
<input type="checkbox"/> Weakness
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Jaw pain | <p>Endocrine:</p> <input type="checkbox"/> Overactive or underactive thyroid
<input type="checkbox"/> Thyroid mass
<input type="checkbox"/> On Prednisone or other steroid | |
| <p>Cardiovascular:</p> <input type="checkbox"/> High cholesterol
<input type="checkbox"/> Angina / chest pain
<input type="checkbox"/> Bypass surgery
<input type="checkbox"/> Angioplasty
<input type="checkbox"/> Irregular heartbeat / palpitations
<input type="checkbox"/> Poor circulation | <p>Urinary:</p> <input type="checkbox"/> Kidney failure/ Dialysis
<input type="checkbox"/> Kidney stones
<input type="checkbox"/> Burning or blood in Urine
<input type="checkbox"/> Urinary infections in the past
Last PSA date _____ | <p>Gyn:</p> <input type="checkbox"/> Vaginal bleeding / Discharge
<input type="checkbox"/> Pelvic pain
Last period, or date of menopause _____
Last Pap date _____ | <p>Psychiatric:</p> <input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Irritability
<input type="checkbox"/> Other mental illness | <p>Cancer Survivor:</p> <input type="checkbox"/> Lung <input type="checkbox"/> Breast
<input type="checkbox"/> Colon <input type="checkbox"/> Prostate
<input type="checkbox"/> Ovarian
<input type="checkbox"/> Other _____
Yr of diagnosis: _____ | |
| <p>Respiratory</p> <input type="checkbox"/> Emphysema
<input type="checkbox"/> Asthma
<input type="checkbox"/> Sleep apnea
<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Chronic cough
<input type="checkbox"/> Hoarseness | <p>Skin:</p> <input type="checkbox"/> Previous skin cancers
<input type="checkbox"/> Melanoma
<input type="checkbox"/> Recent change in a mole
<input type="checkbox"/> Eczema
<input type="checkbox"/> Psoriasis | <p>Hematologic:</p> <input type="checkbox"/> Blood clots
<input type="checkbox"/> Deep vein thromboses (DVT)
<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Anemia
<input type="checkbox"/> Easy bruising / bleeding
<input type="checkbox"/> On Coumadin
<input type="checkbox"/> +HIV | <p>Do you: Smoke?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Not since _____
Packs per day
<input type="checkbox"/> 1/2 <input type="checkbox"/> 1 <input type="checkbox"/> 2 | <p>Drink alcohol?</p> <input type="checkbox"/> None
<input type="checkbox"/> 1-2 drinks/day
<input type="checkbox"/> > 2/day
<input type="checkbox"/> Other _____ | |
| | | | | | <p>Do you: Use any recreational drugs?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | <p>Exercise regularly?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No |

Family history: Father Alive Deceased Medical problems _____
 Mother Alive Deceased Medical problems _____

How many Brothers ____ Sisters? ____ Family members with High blood pressure , heart disease , diabetes , cancer

Please provide additional information on any checked items or other medical problems: _____

Previous surgeries with dates: _____

Allergies: Penicillin , iodine dye , aspirin , codeine , sulfa , latex rubber , other _____

Medications (including nonprescription medications, please provide dosage and frequency if known): _____

Vital Signs (nurse will complete) T _____ BP _____ P _____

 Patient Signature Date

 Physician signature Date

I understand that the above medical information will be used in making Treatment decisions and I attest that it is accurate to the best of my knowledge

I have reviewed the above medical information with the patient.