

**Clinical Questionnaire**

Please complete this form as accurately as possible:

Name: \_\_\_\_\_ Age: \_\_\_\_ Gender: \_\_\_\_

Referring Physician: \_\_\_\_\_

Other Physician currently treating you (& specialty): \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Duration of illness: \_\_\_\_\_

**PAST MEDICAL HISTORY** (Current or past illnesses)

**Heart**

High Blood Pressure  Yes  No

High Cholesterol or lipids  Yes  No

Coronary Artery Disease  Yes  No

Heart Attack  Yes  No

Irregular Heart Beat  Yes  No

Other \_\_\_\_\_

**Lung**

COPD (Emphysema/Chronic Bronchitis)  Yes  No

Asthma  Yes  No

Pneumonia  Yes  No

Other \_\_\_\_\_

**Gastrointestinal**

Reflux Disease (or Hiatal Hernia)  Yes  No

Peptic Ulcer Disease  Yes  No

Gall Bladder Disease  Yes  No

Hepatitis B or C  Yes  No

Other \_\_\_\_\_

**Endocrine**

Diabetes Mellitus  Yes  No

Thyroid disease  Yes  No

Other \_\_\_\_\_

**Cancer**

Ever diagnosed with Cancer?  Yes  No

Year, type & treatment: \_\_\_\_\_

**Blood Disorders**

Anemia  Yes  No

Bleeding disorders/Excessive bleeding  Yes  No

Other \_\_\_\_\_

**Musculoskeletal System**

Osteoarthritis  Yes  No

Gout  Yes  No

Other \_\_\_\_\_

**Peripheral Vascular Disease**

Deep Vein Thrombosis (DVT)  Yes  No

(Blood Clots)

Pulmonary Embolism (PE)  Yes  No

Varicose Veins  Yes  No

Arterial Vascular Disease  Yes  No

Other \_\_\_\_\_

**Psychological Disorders**

Depression  Yes  No

Anxiety  Yes  No

Other \_\_\_\_\_

**Neurologic Disorders**

Stroke  Yes  No

Alzheimer's  Yes  No

Other \_\_\_\_\_

**Other illnesses not listed above:** 1. \_\_\_\_\_

2. \_\_\_\_\_ 3. \_\_\_\_\_

**PAST SURGICAL HISTORY**

Please list all prior surgical procedures:  None

Type of Surgery \_\_\_\_\_ Year \_\_\_\_\_

Type of Surgery \_\_\_\_\_ Year \_\_\_\_\_

Type of Surgery \_\_\_\_\_ Year \_\_\_\_\_

Type of Surgery \_\_\_\_\_ Year \_\_\_\_\_

Have you had a complication after surgery?  Yes  No

If yes, please explain: \_\_\_\_\_

**ALLERGY TO MEDICATIONS**

None

Please list any medication to which you are allergic to:

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

**CURRENT MEDICATIONS**

None

Please list all medications that you are currently using:

	Medications	Dose	Times/ day
1.			
2.			
3.			
4.			

**FAMILY HISTORY**

Has any family member had any of the following:

Difficulty with Anesthesia:  Yes  No

Excessive bleeding after a procedure:  Yes  No

If yes, please explain: \_\_\_\_\_

**SOCIAL HISTORY**

**Tobacco use:**  Current  Past  None

If yes, average use: \_\_\_\_ packets/day; duration: \_\_\_\_ years

Quit (if applicable) \_\_\_\_ years ago

**Alcohol use:**  Current  Past  None

If yes, average use: \_\_\_\_ drinks/week; Type: \_\_\_\_\_

Quit (if applicable) \_\_\_\_ years ago

**Occupation:** \_\_\_\_\_ Employer \_\_\_\_\_

**REVIEW OF SYSTEMS** Please **circle** any of the following symptoms you might have experienced over the past 3 months:

**Constitutional:** Fever, Chills, Tiredness, Weight loss >10%

**Psychologic:** Anxiety, Depression, Difficulty Sleeping

**Neurologic:** Dizziness, Hand/Foot Tingling or Numbness

**Eyes:** Blurry vision, Eye pain

**Ear/Nose/Throat:** Ear ache, Nose Bleed, Change in Voice

**Heart:** Chest Pain, Shortness of Breath, Palpitation

**Lungs:** Cough, Sputum, Shortness of Breath, Wheezing

**Gastrointestinal:** Abdominal pain, Heartburn, Nausea, Vomiting, Bloating, Diarrhea, Constipation, Blood from Rectum

**Genitourinary:** Burning with Urination, Increased Frequency, Difficulty Controlling Bladder, Penile or Vaginal Discharge

**Musculoskeletal:** Pain in Joints, Muscles, or Bones

**Skin:** Skin Rash, Excessive Itching, Eczema, Dry skin

**Hematologic:** Excessive Bruising, Swollen Glands

Patient Signature: \_\_\_\_\_ Date: \_\_/\_\_/\_\_

Surgeon's Comments: \_\_\_\_\_

Surgeon's Signature: \_\_\_\_\_ Date: \_\_/\_\_/\_\_