PATIENT QUESTIONNAIRE

Name:	Birth Date:	Today's Date:
Primary Physician:	Physician's Telephone: ( )	
Physician's Address:		

FAMILY MEDICAL HISTORY (OTHER THAN YOURSELF):	
Relationship to Patient	***Relationship to Patient***
Diabetes:	**Hypertension:**
Cancer:	**Sleep Apnea/Snoring:**
Sinus Disease:	**Other:**

SOCIAL HISTORY:				PREVIOUS SURGERY:
	YES	***NO***	***Comments***	
Do you smoke?	☐	☐		
Do you drink alcoholic beverages?	☐	☐		

CURRENT MEDICATIONS:	ALLERGIES:
1.	1.
2.	2.
3.	3.

HAVE YOU EVER HAD ANY PROBLEMS WITH THE FOLLOWING?

	YES	***NO***	***Comments***		***YES***	***NO***	***Comments***
Fever	☐	☐		High Blood Pressure	☐	☐	
Vomiting	☐	☐		Excessive Thirst	☐	☐	
Headaches	☐	☐		Frequent Urination	☐	☐	
Migraines	☐	☐		Kidney Stones	☐	☐	
Stroke	☐	☐		Kidney Failure	☐	☐	
Seizures	☐	☐		Joint Swelling	☐	☐	
Sinus Problems	☐	☐		Arthritis	☐	☐	
Seasonal Allergies	☐	☐		Skin Rash	☐	☐	
Hoarseness	☐	☐		Bleeding Disorder	☐	☐	
Difficulty Swallowing	☐	☐		Anemia	☐	☐	
Loss of Appetite	☐	☐		Sickle Cell Disease	☐	☐	
Weight Loss/Gain	☐	☐		Easy Bruising	☐	☐	
Deafness	☐	☐		High Cholesterol	☐	☐	
Vertigo	☐	☐		Jaundice	☐	☐	
Asthma	☐	☐		Diabetes	☐	☐	
Tuberculosis	☐	☐		Thyroid Disorder	☐	☐	
Emphysema	☐	☐		Cancer	☐	☐	
Chest Pain	☐	☐		Mental Disorder	☐	☐	
Irregular Heartbeat	☐	☐		Sleep Apnea/Snoring	☐	☐	
Other	☐	☐		Height/Weight:			

Above reviewed and appropriate changes made by:

Nurse's Signature Date

Patient's Signature Date

Physician's Signature Date