

GENERAL QUESTIONNAIRE

Name of the physician who requested your consultation:

Each of the following items is important in helping us find out about the illness that has brought you to see us. *Please answer each question as completely and as accurately as you can.* If you are unsure about a question, please ask one of the medical staff to clarify it.

1. Please briefly describe the health problem that you are seeing us for:

2. How long have you had this problem?

For staff use only:

3. Have you **ever had** any of the following? (please circle all that apply):

| | | | |
|----------------------------------|-------------------------|-----------------------------------|-------------------------------|
| heart murmur | seizures | blood transfusion | tuberculosis (TB) |
| abnormal heart rhythm | syncope/fainting spells | deep vein thrombosis/ blood clots | asthma or shortness of breath |
| high blood pressure | stroke | bleeding problems | pneumonia |
| heart attack | depression | problems with anesthesia | cancer |
| heart failure | substance abuse | diabetes | radiation treatment |
| arthritis | kidney disease | acid reflux | thyroid problems |
| liver disease/jaundice/hepatitis | | sleep apnea | HIV/AIDS |

4. Please list **all** past surgeries:

When? What was done?

—

—
—
—
—
—
—
5. Other conditions you have been treated for:

_____ *Please Turn Over*

6. Current Occupation: _____ Marital Status: _____

Past Occupations: _____

7. Do you currently smoke? yes no Packs/day: _____ Years: _____

Have you smoked in the past? yes no Packs/day: _____ Years: _____

When did you quit? _____

8. Do you drink alcohol? yes no How much? _____/week

9. Have any family members had the same problem you are here to see us for?

yes no If yes, who? _____

10. Do you have any blood relatives who have any of the following conditions? (please circle all that apply):

heart disease

problems with anesthesia

diabetes

high blood pressure

bleeding problems

asthma

stroke

cancer

allergies/hayfever

hearing loss

migraines

tuberculosis

11. Have you had any of these in the last 4 weeks? (please circle all that apply):

General: fatigue chills muscle aches night sweats weight loss weight gain

Skin: dryness itching rash sores/ulcers

Neurologic: headache head trauma fainting paralysis memory loss weakness
numbness tingling

Eyes: glasses/contacts blurring double vision pain drainage

Ears: hearing loss ringing dizziness vertigo ear pain drainage frequent
infections

Nose: trauma congestion loss of smell bleeding drainage

Mouth/Throat: sores bleeding gums dentures loss of taste difficulty swallowing
change in voice feeling of lump in throat

Hormonal: heat/cold intolerance hormone replacement

Blood/Lymph: frequent bleeding easy bruising blood thinners enlarged lymph nodes in neck/groin/armpits
Lungs: shortness of breath frequent cough wheezing
Cardiovascular: chest pain irregular heart beat ankle swelling
Gastrointestinal: heartburn nausea vomiting diarrhea constipation change in appetite blood in stool
Genitourinary: difficulty urinating pain while urinating blood in urine
Musculoskeletal: joint pain bone pain leg pain
Behavioral: depression anxiety substance abuse

For staff use only:
___ I have reviewed the above checked systems with the patient: _____
___ I have completely reviewed all systems with the patient: _____

For staff use only:
I have reviewed this information with the patient: _____ Date: _____
