Rossi and Shirey, MD, PC

*Confidential Medical Questionnaire**

*Information needs to be updated at least annually

Name:	DOB:	Age:	Date:

Chief Complaint/Reason for Visit Today

Physician Use: History of Present Illness

Patient History

Illnesses	Year	Physician
Injuries		
Surgeries		

Allergies	Name	Type of Reaction
Medication		
Food or Other		

Current Medications (Prescription & over the counter drugs, vitamins, herbs)

Name	Dose/How Taken	Name	Dose/How Taken

Family History

	Gender	Age	Living?	Type of Medical Problem
Mother	F		Y N	
Father	M		Y N	
Siblings	M F		Y N	
	M F		Y N	
	M F		Y N	
Children	M F		Y N	
	M F		Y N	
	M F		Y N	
Other	M F		Y N	

Additional Comments: ______________________________

Immunization History

Year of Last Tetanus Shot		Year of Hepatitis B Shot	
Year of Last Flu Shot		Year of Hepatitis A Shot	
Year of Last Pneumovax		Year of Chicken Pox Shot	
Year of Last MMR			

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Name:	DOB:	Age:	Date:

Social History

Occupation:					
Regular Exercise	Y N	Type/Frequency:			
Alcohol Use	Y N	Type/Frequency:			
Tobacco Use	Y N	Packs per Day:	Years:	Year Quit:	Want to Quit? Y N
Recreational Drugs	Y N	Type, if any:			
Seatbelt Use	Y N				
Special Diets	Y N	Please List:			

Review of Symptoms (Circle all that apply & comment whether progressive or current)

General	fatigue, weight gain or loss, fevers, lumps
HEENT	sinus problems, frequent colds, hearing loss, ear aches, eye pain or vision problems Year of last eye exam:
Lungs	shortness of breath, coughing, wheezing, coughing up blood, history of TB or (+) TB skin test
Heart	history of murmur, chest pain, irregular heart beats
GI	indigestion, loss of appetite, changing bowel habits, black stools, blood in stool Year of last proctoscopic exam:
Genito-Urinary	frequent/painful urination, blood in urine, urinary tract infections, nighttime urination, inability to control urination
Extremities	swelling of ankles, varicose veins, pain in legs when walking, blood clots in leg veins
Musculo-skeletal	painful, swollen or aching joints, back pain
Skin	rashes, hives, acne, new or growing moles
Neurological	headaches, convulsions, seizures, weakness, stroke, numbness, problems w/concentration or memory
Psychological	problems sleeping, suicidal thoughts, medicine for nerves/sleep, therapy/counseling, anxious, depressed
Hematology	anemia, easily bruised, blood transfusions, iron supplements

For Men ONLY

genital sores, erection or prostate problems, painful sex, lumps in testicles, discharge, blood

For Women ONLY

breast lumps, tender, nipple discharge, skin changes, premenstrual symptoms, spotting, menopausal symptoms, vaginal infections

bleeding or spotting between cycles	Y	N	date of last menstruation	
history of abnormal Pap smears	Y	N	# of days between cycles	
medication needed for cramps	Y	N	# of days of bleeding	
need for birth control	Y	N	date of last Pap smear	
type of birth control ______			date of last mammogram	

Physician Use: Any Additional Comments