



UNIVERSITY HOSPITALS & CLINICS

Ambulatory Services
Department of Internal Medicine

Confidential Health Questionnaire

Pt. Name: _____

Address: _____

City State Zip

MRN: _____

DOB: _____

SSN: XXX-XX-____ SEX: _____

DOS: _____

Date: _____

Primary Care Physician: _____

Referring Physician: _____

Patient's Current Occupation: _____

Home #: _____

Work #: _____

Reason for visit: _____

Marital Status: Married Single Widowed

Name of Emergency Contact: _____ Relationship: _____

Home Number: _____

Work Number: _____

If the patient is a minor, please provide the information below:

Parent: _____ Relationship: _____ Home #: _____ Work #: _____

Guardian: _____ Relationship: _____ Home #: _____ Work #: _____

With whom does the child reside: _____ Relationship: _____

Preferred Pharmacy #: _____

Current Medications: _____

Herbal products/diet supplements: _____

Allergies: _____

Past Surgeries & Dates: _____

Please describe:

Are you on a special diet? (i.e., low salt, low cholesterol) No Yes

Do you exercise regularly? No Yes

Do you routinely wear a seat belt? No Yes

Do you have any metal in your body? No Yes

Do you have a pacemaker? No Yes

Do you use tobacco? No Yes

Packs per day: _____ Year started _____ Year stopped _____ Type of tobacco: _____

Do you drink alcohol? No Yes

Drinks per day _____ Per week _____

Do you use recreational drugs? No Yes

Females:

Last menstrual period date: _____ Number of pregnancies: _____ Number of live births: _____

Do you do breast exams regularly? No Yes

Males:

Do you do testicular self exams regularly? No Yes

Family History:

Please indicate whether a blood relative has had any of the following:

Cancer Gout High Blood Pressure Lung disease Other

Diabetes Heart Attack Kidney Disease Neurologic disease

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Do you have now, or have you been diagnosed as having: (Fill in all that apply) If yes, explain and provide dates.

- Stroke or "shock"
Anemia
Angina or chest pain
Arthritis
Cancer or tumor
Diabetes mellitus
Heart attack
Heart failure
High blood pressure
Irregular or rapid heart beat
Kidney stones or other disease
Nervous breakdown
Other medical problems
Stomach or duodenal ulcer
Thyroid disease
Varicose veins or blood clots in legs

Have you experienced any of the following since your last visit: (Fill in all that apply)

- General: Fever, Chills, Weight gain/loss, Weakness, Excessive fatigue/tiredness, Change in appetite, Dizziness, Falls, Snoring, Difficulty sleeping, Excessive thirst
Cardiovascular: Chest pains, Heart murmurs, High blood pressure, Leg cramps, Palpitations, Swelling in extremities, Shortness of breath
Eyes: Visual problems, Redness, Discharge, Pain, Tearing
Hematologic/Lymphatic: Easy bruising, Excessive bleeding
Skin: Rashes, Itching/dryness, Hair loss, New/different moles
Genitourinary: Frequent urination, Involuntary loss of urine, Painful urination, Kidney stones, Blood in urine, Frequent infections, Genital lesions, Painful intercourse, Sexual problems, Discharge, Itching, Hernias, Abdominal pain, Heavy menstrual cycles
Allergic/Immunologic: Headache, Hay fever, Asthma, Other pain
Neurological: Fainting, Numbness, Loss of balance, Tingling, Tremors, Memory problems, Hallucinations, Depression, Mood disturbance, Anxiety, Difficulty w/speech, Seizures
Ears/Nose/Throat/Mouth: Hearing loss, Ringing in ears, Nose bleeds, Congestion, Difficulty chewing, Bleeding gums, Hoarseness, Sore throats, Voice changes
Respiratory: Cough, Colored sputum, TB exposure, Wheezing, Coughing up blood, Pneumonia, Bronchitis
Endocrine: Intolerance to cold/heat, Hot flashes, Night sweats, Thyroid problems
Musculoskeletal: Joint pain, Stiffness, Back pain, Neck pain, Gout, Arthritis, Muscle aches, Paralysis

Mark items you would like to discuss with your physician: (Fill in all that apply)

- Weight management or diet
Sexual and reproductive health
Exercise, cardiovascular fitness
Herbs, non-prescription remedies
Other (please describe)
Alcohol or other drug use
Depression, stress, or anxiety
Breast self-examination
Accident prevention and safety
Smoking cessation
Osteoporosis
Menopause, hormone replacement therapy

Have you had the following immunizations:

- Hepatitis B, Tetanus, Flu, Pneumonia
Hepatitis A, TB, Etc.

(Print) Completed by patient or caregiver:
Signature of patient or caregiver:
I have read & reviewed:
Physician's Signature:

INTERNAL MEDICINE