PATIENT LABEL

Patient Questionnaire

Reason for today's visit ______________________________

Medical Problems ______________________________

____

Surgery ______________________________

____

Major Accidents ______________________________

Drug Allergies/reactions ______________________________

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Medications (dose/direction) ______________________________

____

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Preferred Pharmacy and Location ______________________________

Immunizations (date of last): Tetanus________ Pneumonia Vaccine________

Marital Status:__________ **Occupation:** (specify) ____________________

Smoking: Packs per day ______________ Former smoker_______ Quit date__________ Never smoker_______

Alcohol use: Drink(s) per week ________ Type: ☐ wine ☐ beer ☐ mixed drink

Drug use______________________ **Exercise** ______________________

HCM: Colonoscopy ____________ DEXA ____________

Family Status:

	Age if living	Age @ death/cause
Mother	____________	____________________
Father	____________	____________________
Sister(s)	____________	____________________
Brother(s)	____________	____________________
Daughter(s)	____________	____________________
Son(s)	____________	____________________

Females Only:
Last menstrual cycle ____________________
Pregnancies ____________________
Deliveries ____________________
Miscarriage / Abortions____________________
Last Pap __________Last Mammogram ____________
Birth Control ____________________

Family Medical History (specify who):
Heart Attack ____________________
High blood pressure ____________________
High cholesterol ____________________
Stroke ____________________
Diabetes ____________________
Cancer (what type) ____________________
Alcohol/drug abuse____________________
Suicide ____________________
Other ____________________