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PATIENT MEDICAL HISTORY QUESTIONNAIRE

Date _____

Patient Name_____ Sex _____ Age_____ Date of Birth _____
(Please print)

Thank you for completing this one-time, detailed medical questionnaire. Your responses will help Dr. Sarrimanolis provide you with the most comprehensive and optimal medical care possible. Your answers to this questionnaire as well as all of your medical records remain strictly confidential and are protected by federal privacy law.

I. PAST MEDICAL HISTORY

Please check if you have or have had any of the following conditions.

Cardiovascular
- ___ Coronary artery disease
- ___ Prior heart attack
- ___ Prior heart catheterization Date_____
  City/State_____Cardiologist_____
- ___ Prior bypass surgery Date_____
  City/State_____Cardiologist_____
- ___ Valvular heart disease
- ___ Congestive heart failure
- ___ Pacemaker
- ___ Supraventricular tachycardia
- ___ Other arrythmia
- ___ Carotid artery disease
- ___ Peripheral vascular disease
- ___ Pulmonary embolus Date_____
- ___ Deep vein thrombosis
- ___ Superficial phlebitis
- ___ Varicose veins
- ___ High blood pressure
- ___ High cholesterol
- ___ High triglycerides

Eye
- ___ Glaucoma
- ___ Sjorgren's Syndrome

Ear/Nose/Throat
- ___ Seasonal allergic rhinitis
- ___ Chronic sinusitis
- ___ Hearing impairment

Cancer
- ___ Malignancy Type_____
  Date diagnosed_____ Treatment received_____
  _____
  _____

Pulmonary
- ___ Asthma
- ___ COPD (Emphysema/chronic bronchitis)
- ___ Obstructive sleep apnea
- ___ Pneumonia Date_____

Dermatologic
- ___ Skin Cancer Type_____
- ___ Psoriasis
- ___ Rosacea

Musculoskeletal
- ___ Fibromyolgia
- ___ Degenerative joint disease (osteoarthritis)
  Joints affected_____
- ___ Shoulder rotator cuff pathology
- ___ Chronic low back pain
- ___ Spinal disk pathology
- ___ Sciatica ___ R ___ L
- ___ Chronic neck pain
- ___ Joint replacement Which joint(s) _____
  Date(s)_____
- ___ Carpal tunnel syndrome ___ R ___ L
- ___ Gout
- ___ Osteoporosis

Endocrine/Metabolic
- ___ Diabetes ___ Type 1 (juvenile onset) ___ Type 2 (adult onset)
- ___ Hypothyroidism
- ___ Hyperthyroidism
- ___ Grave's disease
- ___ Multinodular goiter
- ___ Obesity

Genitourinary
- ___ Chronic kidney disease
- ___ Kidney stones Number of episodes ___
- ___ Frequent urinary tract infections
- ___ Urinary incontinence
- ___ Benign prostatic hypertrophy
- ___ Sexual dysfunction
- ___ Sexually transmitted diseases Type_____Date _____

Autoimmune/HIV
- ___ AIDS/HIV+
- ___ Rheumatoid arthritis
- ___ Systremic lupus erythenotosis

Liver
- ___ Chronic hepatitis B
- ___ Chronic hepatitis C
- ___ Prior hepatitis A
- ___ Fatty liver disease
- ___ Abnormal liver function tests
- ___ Cirrhosis

Gastrointestinal
- ___ Barrett's esophagus
- ___ GERD (gastroesophageal reflux disease)
- ___ Stomach ulcers
- ___ Gastrointestinal bleeding Date _____
- ___ Gastritis
- ___ Celiac sprue
- ___ Crohn's disease
- ___ Ulcerative colitis
- ___ Colon polyps
- ___ Irritable bowel syndrome
- ___ Chronic constipation
- ___ Diverticulosis
- ___ Internal hemorrhoids
- ___ External hemorrhoids

Hematologic
- ___ Anemia ___ Thalassenia minor ___ Vitamin B12 deficiency

Neurologic
- ___ Stroke Side affected ___ R ___ L Date _____
- ___ TIA (mini-strokes)
- ___ Seizure disorder
- ___ Peripheral neuropathy Limbs affected _____
- ___ Migraine headaches
- ___ Tension headaches
- ___ Dementia
- ___ Parkinson's disease
- ___ Multiple sclerosis

Gynecological
- ___ Currently pregnant
- ___ Prior pregnancies How many? ___
- ___ Prior miscarriages How many? ___
- ___ Pregnancy complications (please describe)_____
  _____
- ___ Polycyctic ovary syndrome
- ___ Dysfunctional uterine bleeding
- ___ Post-menopausal ___ Natural ___ Surgical

Psychiatric
- ___ Depression
- ___ Seasonal affective disorder
- ___ Premenstrual depression
- ___ Anxiety disorder
- ___ Bi-polar disorder

Other Conditions (please list)_____
_____
_____

Please turn to page 2 to continue.

II. SURGERIES

Please check all that apply. **Date**

___ Tonsillectomy _____
___ Gallbladder _____
___ Appendectomy _____
___ Inguinal hernia repair ___ R ___ L _____
___ Abdominal hernia repair _____
___ Hysterectomy ___ Abdominal ___ Vaginal
___ Ovaries removed ___ Ovaries intact _____
___ Tubal ligation _____
___ C-section How many? ____ _____
___ Cataract surgery ___ R ___ L _____
___ Arthroscopic surgery
Joint involved _____ _____
___ Joint replacement
Joint involved _____ _____
___ Other surgeries

_____ _____
_____ _____
_____ _____

III. BLOOD TRANSFUSIONS ___ No

___ Yes Date _____

IV. HOSPITALIZATIONS other than surgery/SERIOUS ILLNESSES

Description	Date	Hospital/City/State

V. CURRENT MEDICATIONS

Please list all prescription and nonprescription medications, vitamins, supplements, herbals, etc.

Name	Dosage (mg)	Frequency

VI. ALLERGIES *Please list all allergies you have experienced.*

_____
_____
_____

VII. FAMILY HISTORY

If deceased, please describe cause of death.

Mother: Living (age) _____ Deceased (age) _____
Health problems: _____
_____

Father: Living (age) _____ Deceased (age) _____
Health problems: _____
_____

Brother(s): How many?_____ Health problems: _____
_____

Sister(s): How many?_____ Health problems: _____
_____

Children: How many?_____ Health problems: _____
_____

Maternal Grandmother: Health problems: _____
_____

Paternal Grandmother: Health problems: _____
_____

Maternal Grandfather: Health problems: _____
_____

Paternal Grandfather: Health problems: _____
_____

Please check if you have any family history of the following. **Which relative?**

___ **Anemia** _____
___ **Hypertension** _____
___ **Coronary artery disease** _____
(heart attack, bypass surgery, angina)
___ **Heart arrhythmia** _____
___ **Premature sudden death** _____
(younger than age 50)
___ **Stroke** _____
___ **Diabetes:**
___ **Type I** (juvenile onset) _____
___ **Type II** (adult onset) _____
___ **Elevated cholesterol or tryglycerides** _____
___ **Thyroid disease** _____
___ **Other endocrine disease** _____
___ **Kidney disease** _____
___ **COPD** (emphysema/chronic bronchitis) _____
___ **Other lung disease** _____
___ **Brain aneurisms** _____
___ **Liver disease** _____
___ **Cancer Type**_____ _____
___ **Stomach ulcers** _____
___ **Inflammatory bowel disease** _____
(Chron's, ulcerative colitis)
___ **Thalassemia** _____
___ **Autoimmune or connective tissue disease:**
___ **Lupus** _____
___ **Rheumatoid arthritis** _____
___ **Other** _____ _____
___ **Hypercoagulable disorders** (blood clots) _____
___ **Bleeding disorders** _____
___ **Psychiatric disorders** _____

VIII. SOCIAL HISTORY

Marital Status:

___ Single ___ Married ___ Divorced ___ Widowed

Occupation: _____

Employer: _____

If retired, from which occupation? _____

Tobacco use:

___ Never smoked ___ Presently chew

___ Presently smoke # of packs /day___ # of years___

___ Quit smoking Year quit_____ # of years smoked___

# of packs /day smoked___

Caffeine use: ___ No

___ Yes Number of caffeinated beverages/day ___

Alcohol use: ___ No

___ Yes Number of drinks/day ___ Number of drinks/week___

Drug use: ___ No

___ Yes ___ Marijuana ___ Cocaine ___ IV drug use ___ Other

Regular exercise: ___ No ___ Yes Type_____

Duration _____ Frequency _____

Do you eat a balanced diet? ___ Yes ___ No _____Explain:

_____

_____

_____

IX. HEALTH MAINTENANCE AND PREVENTIVE MEASURES

Please check if you have had the following. **Year last performed**

___ Colonoscopy _____

___ Flexible sigmoidoscopy _____

___ EGD (Esophagogastroduodenoscopy) _____

Male

___ PSA _____

___ Digital rectal examination _____

___ Testicular examination (if younger than 45)_____

Female

___ Pap and pelvic _____

___ Breast examination _____

___ Mammogram _____

___ Bone Density Scan _____

IMMUNIZATION STATUS

Please check if you have had the following immunizations.

___ Childhood vaccinations

___ Hepatitis A

___ Hepatitis B

___ BCG (tuberculosis)

___ Tetanus/Diphtheria Last year given _____

___ Pneumococcal (pneumonia) Last year given _____

___ Influenza virus (flu) Last year given _____

X. REVIEW OF SYMPTOMS

Please indicate any recent (within past three months) symptoms.

Constitutional

___ Overall general health ___ good ___ poor

___ Weight loss Number of lbs. _____

Over how many months? _____

___ Weight gain Number of lbs. _____

Over how many months? _____

___ Fatigue

___ Generalized weakness

___ Poor appetite

___ Fever

___ Chills

___ Night sweats

Respiratory

___ Chronic cough

___ Shortness of breath ___ at rest ___ with mild exertion

___ Wheezing

___ Coughing blood

___ Coughing phegm

Skin

___ Large or changing moles

___ Rash

___ Hives

___ Itching

___ Lumps or bumps

___ Easy bruising

___ Hair loss

___ Other lesions

Ears, Nose, Eyes

___ Hearing

___ Vertigo

___ Earaches or discharge

___ Postnasal drip

___ Seasonal allergies

___ Chronic sinus problems

___ Frequent nose bleeds

___ Loud or problem snoring

___ Abrupt vision loss

___ Blurred vision

___ Double vision

___ Wear corrective lenses

___ Eye pain or redness

___ Loss of peripheral vision

Mouth and Throat

___ Difficulty swallowing

___ Painful swallowing

___ Frequent sore throat

___ Hoarseness

___ Mouth sores

___ Bleeding gums

___ Gum disease

___ Problems with teeth

Cardiovascular

___ Chest pain ___ at rest ___ with exertion

___ Shortness of breath ___ at rest ___ with mild exertion

___ while lying flat ___ at night

___ Palpitations

___ Swelling of feet or ankles

___ Irregular heart beat

___ Rheumatic fever

___ Heart murmur

Please turn to page 4 to continue.

REVIEW OF SYMPTOMS, continued

Please indicate any recent (within past three months) symptoms.

Endocrine

___ Cold intolerance
___ Heat intolerance
___ Goiter
___ Thyroid nodules
___ Excessive appetite
___ Hot flashes

Neurological

___ Headaches
___ Tremors
___ Seizures
___ Paralysis
___ Numbness or tingling Location _____
___ Arm or leg weakness Location _____
___ Gait instability
___ Speech difficulty
___ Difficulty with coordination
___ Loss of consciousness
___ Dizziness
___ Falls
___ Poor concentration
___ Memory loss

Blood, Lymphatics and Immune Systems

___ Anemia
___ Excessive bruising or bleeding
___ Swollen or tender lymph glands
___ Immune system problems
___ AIDS/HIV+

Musculoskeletal

___ Joint pain Which joint(s) _____
___ Joint swelling Which joint(s) _____
___ Joint stiffness Which joint(s) _____
___ Muscle aches or pain Which muscle(s) _____
_____
___ Muscle weakness Which muscle(s) _____
_____
___ Back pain
___ Difficulty walking
___ Cold extremities
___ Varicose veins

Breasts

___ Masses or swelling
___ Tenderness
___ Discharge

Genitourinary

___ Urinary frequency
___ Urinary urgency
___ Uriniary incontinence
___ Painful or burning urination
___ Blood in urine
___ Tea-colored urine
___ Discharge from penis or urethra
___ Genital lesions
___ Sexual difficulty

Males

___ Urinary hesitancy
___ Urinary dribbling
___ Need to awaken to urinate
Number of times per night ___
___ Diminished urinary stream
___ Other prostate problems
___ Testicular swelling or pain

Females

___ Vaginal bleeding between menses
___ Heavy menses
___ Pain with menses

Psychiatric

___ Depression
___ Anxiety
___ Nervousness
___ Hallucinations
___ Insomnia
___ Thoughts of suicide

Gastrointestinal

___ Heartburn
___ Abdominal pain Location _____
___ Nausea
___ Vomiting
___ Indigestion
___ Excessive belching or bloating
___ Vomiting blood
___ Bowel movement alterations
___ Painful bowel movements
___ Diarrhea
___ Constipation
___ Excessive flatus
___ Rectal bleeding or blood in stool
___ Black or tarry stools
___ Gray colored stools
___ Perianal pain or irritation
___ Hemorrhoids
___ Jaundice (yellow skin)
___ Food allergies

Thank you, again, for filling out this detailed questionnaire. By signing below, you certify that the information provided above is accurate and true to the best of your knowledge.

Patient Signature _____ Date _____

FOR OFFICE USE ONLY.

DATES FORM REVIEWED BY DOCTOR (Please initial and date.)

Initial _____	Date _____	Initial _____	Date _____	1nitial _____	Date _____
Initial _____	Date _____	Initial _____	Date _____	1nitial _____	Date _____
Initial _____	Date _____	Initial _____	Date _____	1nitial _____	Date _____
Initial _____	Date _____	Initial _____	Date _____	1nitial _____	Date _____

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