Family Practice Group

A Rogue Valley Physicians, PC clinic

Welcome to FAMILY PRACTICE GROUP

Please help us by completing this QUESTIONNAIRE

DATE: _____

NAME: _____

PHONE: _____

BIRTHDAY: _____

*** Personal Information**

WHERE ARE YOU FROM? _____ HOW DID YOU HEAR ABOUT US? _____

REASON FOR THIS VISIT: _____ PREVIOUS PHYSICIAN: _____

MARITAL STATUS: _____ LIST MEMBERS IN YOUR HOUSEHOLD: _____

_____

OCCUPATION: _____ HOBBIES/PASTTIMES: _____ EDUCATION: _____

*** Medical Information**

CURRENT MEDICATIONS AND DOSES (include herbs, vitamins, non-prescriptions): _____

_____

List Allergies to medications and what happens: _____

List any medications you have used in the past: _____

CHECK ALL CURRENT OR PAST HEALTH PROBLEMS THAT APPLY TO YOU

☐ ANXIETY	☐ DIVERTICULOSIS	☐ LIVER DISEASE	☐ PNEUMONIA	☐ TUBERCULOSIS
☐ ARTHRITIS	☐ HERNIA	☐ LUNG DISEASE	☐ SEXUAL DISEASES	☐ ULCERS
☐ CHRONIC PAIN	☐ HIV/AIDS	☐ OSTEOPOROSIS	☐ SKIN PROBLEMS	☐ OTHER: (if not below) _____
☐ DEPRESSION	☐ JAUNDICE	☐ PANCREATITIS	☐ THYROID	☐ OTHER: _____

Please describe hospitalizations starting with most recent, do not include normal pregnancies, check this box [ ] if there are more than four

	Date	Operation or Illness	Name of Hospital	City, State	Doctor
1st Hospitalization					
2nd Hospitalization					
3rd Hospitalization					
4th Hospitalization					

NUMBER OF PREGNANCIES:_____ NUMBER OF LIVE BIRTHS:_____ NUMBER OF LIVING CHILDREN:_____ LAST PERIOD:_____

*** Preventive Health**

Number of caffeinated drinks per day: _____

TOBACCO USE: How much? _____ , if quit, when? _____ , used for _____ years total

ALCOHOL USE: How much? _____ , if quit, when? _____ , used for _____ years total

DRUG USE: Which drugs have you used? _____ , IV use? [ ] yes [ ] no Last use? _____

PLEASE write in date these were last done and CHECK BOX ONLY IF ABNORMAL

☐ MAMMOGRAM_____	☐ PNEUMONIA VACCINE_____	☐ ABDOMINAL X-RAY_____	☐ APPENDIX REMOVAL_____
☐ PAP SMEAR_____	☐ CHOLESTEROL CHECK_____	☐ ULTRASOUND_____	☐ GALLBLADDER REMOVAL_____
☐ TETANUS SHOT_____	☐ CHEST X-RAY_____	☐ SIGMOIDOSCOPY_____	☐ HYSTERECTOMY_____
☐ TB TEST_____	☐ GI SERIES_____	☐ COLONOSCOPY_____	☐ OTHER_____
	☐ EKG_____	☐ GASTROSCOPY_____	☐

*** Family History**

Write in age and check any boxes that apply	LIVING (AGE)	DECEASED (AGE AT DEATH)	ALLERGIES OR ASTHMA	ANEMIA	ARTHRITIS	BLOOD CLOTS	CANCER	CHILD ABUSE	DIABETES	DRINKING PROBLEM	DRUG ADDICTION	EPILEPSY	GENETIC DISEASE	GLAUCOMA	GOUT	HEART PROBLEMS	HIGH BLOOD PRESSURE	INTESTINE PROBLEMS	KIDNEY PROBLEMS	PSYCHIATRIC PROBLEMS	STROKE	OTHER
YOURSELF																						
FATHER																						
MOTHER																						
SIS/BRO																						
CHILDREN																						

PLEASE TURN PAGE OVER

CHECK ALL BOXES THAT APPLY TO YOU

General

- [ ] fever or chills
- [ ] sweats
- [ ] appetite changes
- [ ] weight loss
- [ ] weight gain
- [ ] fatigue/exhaustion
- [ ] want to quit smoking

Eyes

- [ ] eye irritation
- [ ] blurring
- [ ] eye pain
- [ ] discharge
- [ ] light sensitivity
- [ ] change in vision

Ears, nose, throat

- [ ] ringing in ears
- [ ] ear discharge
- [ ] earaches
- [ ] decrease hearing
- [ ] nosebleeds
- [ ] hoarseness
- [ ] sore throat
- [ ] problems with teeth
- [ ] sore gums or tongue

Cardiovascular

- [ ] awaken short of breath
- [ ] lightheadedness
- [ ] fainting
- [ ] chest pain/pressure
- [ ] racing heart
- [ ] skipping heart beat
- [ ] pounding heart
- [ ] short of breath at rest
- [ ] or when active
- [ ] swollen ankles or hands
- [ ] blue lips or nails

Respiratory

- [ ] chronic cough
- [ ] cough up blood
- [ ] wheezing
- [ ] excessive snoring

Intestinal

- [ ] indigestion/heartburn
- [ ] difficulty swallowing

Intestinal continued

- [ ] vomiting blood
- [ ] nausea
- [ ] excessive gas/bloating
- [ ] abdominal pain
- [ ] hernia
- [ ] hemorrhoids
- [ ] diarrhea
- [ ] change in bowel habits
- [ ] constipation
- [ ] black bowel movement
- [ ] bloody bowel movement

Urinary/Genital

- [ ] strong odor
- [ ] discharge
- [ ] bloody urine
- [ ] frequent urination
- [ ] can't empty bladder
- [ ] trouble starting urine
- [ ] painful urination
- [ ] night frequency
- [ ] can't control bladder
- [ ] genital sores
- [ ] less interest in sex
- [ ] genital or pelvic pain
- [ ] pain with sex

For Men

- [ ] penis discharge
- [ ] pain or lump in testicle
- [ ] weak stream
- [ ] erection problems

For Women

- [ ] heavy/irregular flow
- [ ] bleeding after sex
- [ ] vaginal itching
- [ ] breast pain
- [ ] breast lumps
- [ ] nipple discharge
- [ ] abnormal pap smear
- [ ] problem pregnancy

Musculoskeletal

- [ ] muscle cramps
- [ ] joint pain/stiffness
- [ ] joint swelling
- [ ] back/neck pain
- [ ] muscle weakness

Musculoskeletal continued

- [ ] muscle aches
- [ ] bone pain
- [ ] calf pain with walking

Skin

- [ ] suspicious lesions
- [ ] poor wound healing
- [ ] skin cancer
- [ ] itching or burning
- [ ] change in skin color
- [ ] rash

Neurologic

- [ ] poor balance
- [ ] headaches
- [ ] numbness or tingling
- [ ] can't speak
- [ ] falling
- [ ] paralysis
- [ ] seizures
- [ ] room spinning
- [ ] tremors
- [ ] excessive sleepiness
- [ ] memory loss

Psychiatric

- [ ] anxiety/nervousness
- [ ] suicidal thoughts
- [ ] depression
- [ ] violent thoughts
- [ ] hallucinations
- [ ] problems sleeping
- [ ] moodiness
- [ ] alcohol problems
- [ ] drug problems
- [ ] domestic violence

Endocrine

- [ ] excess hunger
- [ ] always cold
- [ ] always hot
- [ ] excess thirst

Blood Disorders

- [ ] enlarged lymph nodes
- [ ] trouble stopping bleeding
- [ ] easy bruising
- [ ] cancer

Allergies

- [ ] seasonal allergies
- [ ] hives or rashes