GENERAL QUESTIONNAIRE

Name of the physician who requested your consultation:
____________________________________________________________________________________

Each of the following items is important in helping us find out about the illness that has brought you to see us. Please answer each question as completely and as accurately as you can. If you are unsure about a question, please ask one of the medical staff to clarify it.

1. Please briefly describe the health problem that you are seeing us for: __________________
_________________________________________________________________________
_________________________________________________________________________

2. How long have you had this problem? __________________________________________

3. Have you ever had any of the following? (please circle all that apply):
   - abnormal heart rhythm
   - acid reflux
   - arthritis
   - asthma/shortness of breath
   - bleeding problems
   - blood transfusion
   - cancer
   - deep vein thrombosis/blood clots
   - depression
   - diabetes
   - heart attack
   - heart failure
   - heart murmur
   - high blood pressure
   - HIV/AIDS
   - kidney disease
   - liver disease/jaundice/hepatitis
   - pneumonia
   - problems with anesthesia
   - radiation treatment
   - seizures
   - sleep apnea
   - stroke
   - substance abuse
   - syncope/fainting
   - spells
   - thyroid problems
   - Tuberculosis (TB)

4. Have you had any of these in the LAST 4 WEEKS? (Please circle all that apply):
   - General: chills fatigue muscle aches night sweats weight gain weight loss
   - Skin: dryness itching rash sores/ulcers
   - Neurologic: fainting headaches head trauma memory loss numbness paralysis weakness tingling
   - Eyes: blurring double vision drainage glasses/contacts pain
   - Ears: dizziness drainage ear pain frequent infections hearing loss ringing vertigo
   - Nose: bleeding congestion drainage loss of smell trauma
   - Mouth/Throat: bleeding gums change in voice dentures difficulty swallowing feeling of lump in throat sores
   - Hormonal: cold intolerance heat intolerance hormone replacement
   - Blood/Lymph: blood thinners easy bruising enlarged lymph nodes in neck/groin/armpits frequent bleeding
   - Lungs: frequent cough shortness of breath wheezing
   - Cardiovascular: ankle swelling chest pain irregular heartbeat
   - Gastrointestinal: blood in stool change in appetite constipation diarrhea heartburn nausea vomiting
   - Genitourinary: blood in urine difficulty urinating pain while urinating
   - Musculoskeletal: bone pain joint pain leg pain
   - Behavioral: anxiety depression substance abuse
5. **ALLERGIES TO MEDICATIONS:**

Medication:             Reaction:
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

6. List All Medications and amounts you are currently taking (prescription and over the counter)

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

7. Do you have any blood relatives who have any of the following conditions? (Please circle all that apply): Please indicate which family member each condition relates to.  
   - allergies/hayfever 
   - diabetes 
   - migraines 
   - asthma 
   - hearing loss 
   - problems with anesthesia 
   - bleeding problems 
   - heart disease 
   - stroke 
   - cancer 
   - high blood pressure 
   - Tuberculosis

8. Other conditions you have been treated for:
_________________________________________________________________________

9. List all past surgeries and date.
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

10. Marital Status: ____________________________
11. Current Occupation: ____________________________