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	deep vein thrombosis/ blood clots	HIV/AIDS	seizures
acid reflux	depression	kidney disease	sleep apnea
arthritis	diabetes	liver disease/ jaundice/hepatitis	stroke
asthma/ shortness of breath	heart attack	pneumonia	substance abuse
bleeding problems	heart failure	problems with anesthesia	syncope/fainting spells
blood transfusion	heart murmur	radiation treatment	thyroid problems
cancer	high blood pressure		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: _____