Lake Village Clinic

History Questionaire

Patient's Full Name: ____

Spouse or Responsible Party: ____ Date of Birth: ______________

Address: ____________________________________ City: ________________ State: _____ Zip: _______

Home Phone: ______________________________ Work Phone: __________________________________

Date of Last Physical Exam: ______________________ Date of Last Pap Smear: __________________________

Personal History (Yes or No)
_______Diabetes
_______Tuberculosis
_______Cancer
_______Heart Disease
_______High Blood Pressure
_______Blood Disease
Other Diseases not mentioned ____

Operations, Injuries, and approximate dates: ____

____

____

Hospitalizations (X-rays & EKG's), other than for operations: ______________________________

____

____

____

Diet Restrictions: _______Yes _______ No

Smoke: _______Yes _______No

Living Will: _______Yes _______No

Marital Status: Single, Married, Divorced, Widowed Number of Children: ______________

Immunizations: Last Tetanus _________________ Influenza ________________ Pneumovax __________

Work History: Toxin Exposure: _______Yes _______No

Retired: _______Yes _______No

Medical Disability: _______Yes _______No

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History Questionaire (continued)

Family History
If Living: Age and Medical Problems
If Deceased: Age at Death and Cause of Death

Father: ______________________________

Mother: ______________________________

Brother (s): ______________________________

Sister (s): ______________________________

Is there a family history of:

	Yes	No	Relationship
Diabetes			
Cancer			
Stroke			
Hypertension			
Arthritis			
Heart Disease			
Other			

List all the medications (Prescription and Over the Counter) you are currently taking. Include dose (mgm) and how many times a day your take each one.

Medication	Dose (mgm)	How Often?

Allergies:

Drugs: ______________________________

Food: ______________________________

Other: ______________________________

History Questionaire (continued)

Lake Village Clinic

STUDY OF SYSTEMS
Check Yes or No for each item except whre applies to male or female

	Condition	Yes	No
	Fever		
	Chills		
	Bruise Easily		
	Swollen Glands		
	Loss of Memory		
	Genreal Weakness		
	Aches/Pains		
Head	Double Vision		
	Light Flashes		
	Blurred Vision w/o Glasses		
	Halos Around Lights		
	Eye Pains		
	Ear Pains		
	Ear Drainage		
	Buzzing/Ringing in Ears		
	Nosebleeds		
	Sinus Problems		
	Swallowing Problems		
	Deafness		
	Mouth, Tooth or Tongue Problems		
	Persistent Hoarseness		
	Servre Headaches		
	Other*		
	Rash		
	Changing Moles		
	Pigmentation		
	Other Skin Problems*		
Chest Heart Lungs	Irregular Heartbeat		
	Shortness of Breath		
	Low Exercise Tolerance		
	Heart Flutters		
	Chest Pains		
	Frequent Coughs		
	Cough Up of Blood		
	Wheezing		
	Night Sweats		
	Swollen Ankle		
	Cramps in Legs		
	Other*		

	Condition	Yes	No
Neck	Stiffness		
	Swelling		
	Lumps		
	Other*		
Gastrointestinal	Appetite Poor		
	Indigestion/Heartburn		
	Nausea		
	Vomiting Blood		
	Abdominal Pain or Cramps		
	Abdominal Tension		
	Biarrhea		
	Constipation		
	Bowel Habit Changes		
	Rectum Blood Passage		
	Black Tar-Type Bowel Movements		
	Other*		
Kidney	Up Nights to Urinate		
	Blood in Urine		
	Burning or Pain While Urinating		
	Problems Passing Urine		
	Trouble Controlling Urine		
	Other*		
Neu Musc	Leg or Arm Weakness		
	Balance Problems		
	Dizziness		
	Fainting Spells		
	Speech Problems		
	Other*		
Bone Joint	Joint Pains		
	Joint Swelling		
	Muscle Strength Loss		
	Muscle Lump or Swelling		
	Lump on Bone		
	Pains in Back		
	Other*		
Endocrine	Constant Thirst		
	Most Always Cold		
	Too Warm Most Times		
	Very Sluggist or Tired		
	Jumpy / Nervous		

	Condition	Yes	No
Psychological	**Is Your Life:**		
	Satisfactory		
	Boring		
	Demanding		
	Unsatisfactory		
	Is There Worry Over:		
	Home Life		
	Marriage		
	Job		
	Children		
	Money		
	Do You:		
	Often feel Depressed		
	Have Irrational Fears		
	Feel Upset		
	Feel Things Often Go Wrong		
	Feel Shy		
	Cry Easily		
	Feel Inferior		
	Have You:		
	Attempted Suicide		
	Seriously Considered Suicide		
Men Genitalia	Lump In Testicle		
	Penis Discharge		
	Breast Lump		
	Sore on Penis		
	Erection Difficulites		
	Other*		
Women Genitalia	Breast Lump		
	Nipple Discharge		
	Vaginal Discharge		
	Non-Period Bleeding/Spoting		
	Hot Flashes		
	Pain with Intercourse		
	Possibly Pregnant		
	Change in Periods		
	Pain Other Than with Periods		
	Other*		

Explain Other*

Doctor’s Use Only - Summary