AI^3 Health Questionnaire

Name:_____ **Date of Birth:**_____ **Height:**_____ **Weight:**_____

What is the medical problem you need addressed today?

_____
_____

How long have you had this problem?

_____

Which doctor referred you to us? (If none, tell us how you found out about us)

_____

Have you had any imaging studies done for this problem (MRI, Ultrasound, ect.), if so, where/when?

_____

Please list all the health problems you have:

- □ High Blood Pressure
- □ High Cholesterol
- □ Acid Reflux
- □ Cancer (Type:_____)
- □ Coronary Artery Disease
- □ Peripheral Vascular Disease
- □ Heart Attack
- □ Stroke
- □ Kidney Problems (Type:_____)
- □ Chronic Back Pain
- □ Diabetes
- □ C.O.P.D
- □ Asthma
- □ Sleep Apnea
- □ Osteoporosis
- □ Varicose Veins
- □ Uterine Fibroids
- □ DVT/PE
- □ Heart Problems (Type:_____)
- □ _____
- □ _____
- □ _____
- □ _____

List your allergies or reactions to medication:

- _____Reaction:_____
- _____Reaction:_____
- _____Reaction:_____

Are you allergic to contrast dye, IVP dye, or iodine? □ YES □ NO

Please list your current medications (dosage and frequency):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you take any form of Aspirin?
□ NO □ 81mg (“baby”) □ 325mg

Please list your family’s medical history:

Father’s age _____ or age at death_____
His medical problems: _____
_____
Mother’s age _____ or age at death_____
Her medical problems: _____
_____
Other medical problems your siblings suffer from: _____
_____

Do you use tobacco: □ YES □ NO □ PAST
If yes, or in the past, how many packs per day _____and for how many years?_____

Do you drink alcohol: □ YES □ NO □ PAST
How often?_____

Do you use drugs: □ YES □ NO □ PAST
What kind:_____

Current Occupation and Employer:
_____

Please list all surgeries you have had:

_____
_____
_____
_____
_____
_____

More space available on back if needed

Review of Systems.

Please check which symptoms you have experienced in the past 6 months.

Constitutional:
- □ Fatigue
- □ Chills
- □ Night sweats
- □ Fever
- □ Weight change
- □ Change in appetite

Skin:
- □ Rash
- □ New lumps or bumps
- □ Skin Cancer
- □ Changes in skin color

HEENT:
- □ Nose bleeds
- □ Hearing loss
- □ Blurred vision
- □ Difficulty swallowing
- □ Swollen lymph nodes

Cardiovascular:
- □ Irregular heart beat
- □ Pacemaker or Defibrillator
- □ Nonhealing ulcer or sore
- □ Chest pain
- □ Leg swelling
- □ Leg pain with walking

Endocrine:
- □ Cold or heat intolerance
- □ Thyroid problems
- □ Hair changes

Gastrointestinal:
- □ Abdominal pain
- □ Bloating or belching
- □ Blood in stool
- □ Change in bowel habits
- □ Heartburn
- □ Hemorrhoids
- □ Nausea or vomiting
- □ Liver problems

Hematology:
- □ Easy bleeding or bruising
- □ Clotting disorder

Gynecologic (women only):
- □ Heavy menstrual cycle
- □ Pain or lump in breasts
- □ Irregular bleeding
- □ Painful periods

Date of last period:____/____/____
# of pregnancies: _____
# of live births: _____

Musculoskeletal:
- □ Joint swelling
- □ Joint pain
- □ Joint stiffness

Respiratory:
- □ Cold Symptoms
- □ Shortness of breath
- □ Persistent cough
- □ Wheezing
- □ Coughing blood

Genitourinary:
- □ Difficulty urinating
- □ Urinary incontinence
- □ Urinary frequency
- □ Blood in urine
- □ Decrease in sexual function

Neurological:
- □ Headaches
- □ Decrease in strength (Where?_____)
- □ Numbness/Tingling (Where?_____)
- □ Seizures
- □ Fainting or blackouts

Psychiatric:
- □ Depression
- □ Anxiety
- □ Dementia or Alzheimer's Disease

ADDITIONAL SPACE:

_____
_____
_____
_____
_____

I certify the information above is correct to the best of my ability:

Sign/Date:_____