

AI³ & CVHS 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: _____)
- Multiple Myeloma
- Sickle Cell Disease
- Pheochromocytoma
- _____

List your allergies or reactions to medication:

Reaction: _____
Reaction: _____
Reaction: _____
Are you allergic to contrast dye, IVP dye, or iodine? YES NO

Current Occupation and Employer: _____

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: _____

Please list all surgeries you have had:

Emergency Contact: _____
Phone: _____ Relation: _____
Who may we share your health information with (family or other persons)?

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: _____