Amarillo Diagnostic Clinic, P.A.

DOUGLAS LEWIS, D.O.

PATIENT QUESTIONNAIRE - PLEASE PRINT

Full name:____Date:_______________________Age:__________

Referring Physician:______________________________________Primary Care doctor________________________

Please answer all questions. If you do not know the answer, insert a question mark in the space.

Which hand do you prefer to use? (Circle) Left Right

MAJOR COMPLAINT(S): List the main reason(s) why you are here and when each problem began.

1) ____Date started_________________

2)____Date started_________________

3)____Date started_________________

PAST SURGICAL HISTORY

1) ____Surgeon___________________________Date__________

2)____Surgeon___________________________Date__________

3)____Surgeon___________________________Date__________

4)____Surgeon___________________________Date__________

LIST ALL LONG STANDING MEDICAL CONDITIONS

1) ____Date of onset________________

2)____Date of onset________________

3)____Date of onset________________

4)____Date of onset________________

CHECK ALL OF THE FOLLOWING CONDITIONS WHICH YOU HAVE EXPERIENCED

☐ Thyroid Disease	☐ Heart disease	☐ Back injury
☐ Anemia	☐ Tension/Anxiety/Nerves	☐ Stomach ulcers
☐ Blood clots	☐ Exposure to poisons	☐ Depression
☐ Cancer	☐ Seizures – as child	☐ Physical abuse
☐ Diabetes	☐ Seizures – as adult	☐ Sexual abuse
☐ Kidney stones	☐ Stroke	☐ Psychiatric treatment
☐ Liver disease	☐ Head injury	☐ Miscarriage
☐ Sexually transmitted diseases	☐ Coma	☐ Other______________
☐ High blood pressure	☐ Neck injury	

HAS ANY BLOOD RELATIVE EVER HAD ANY OF THE FOLLOWING? IF SO, INDICATE RELATIONSHIP

_____________________Epilepsy/Seizures	_____________________Cancer	______________Stroke
_____________________Headache	_____________________Diabetes	______________Tremor

PLEASE LIST ALL MEDICATIONS & SUPPLEMENTS *(including vitamins and aspirin)* THAT YOU ARE CURRENTLY TAKING. Give the name, the strength of each dose, how often taken, and when you began taking it.			
Name of medication	**Strength**	**How often**	**When began**

PLEASE LIST ALL MEDICATIONS THAT YOU ARE ALLERGIC TO, WITH TYPE OF REACTION		
Name of medication	**Strength**	**Reaction**

SOCIAL HISTORY

Current marital status? □ Single □ Married □ Separated □ Divorced □ Widowed □ Other

Number of children___________ Years of school______________ Degree_____________________

Occupation____

HABITS

Have you ever smoked cigarettes regularly? □ Yes □ No If yes, how many packs per day? (avg)

How many years? Are you still smoking? □ Yes □ No If no, when did you stop?

Do you use snuff or chewing tobacco? □ Yes □ No Do you drink alcohol? □ Yes □ No

How many beers daily? How many years?

How many mixed drinks or glasses of wine daily? How many years?

Do you have any drug, nicotine or alcohol habits which concern you? □ Yes □ No

Do you regularly use sleeping pills, tranquilizers, or pain killers? □ Yes □ No

If yes, which ones?

Do you currently use marijuana, cocaine or other “recreational” drugs? □ Yes □ No

FAMILY HISTORY

Please give the following information about the health of your immediate family.

Father's History

Is your Father? □ Alive – Age ________________ □ Deceased – Age ____________________

Major health problems and/or cause of death?

Mother's History

Is your Mother? □ Alive – Age ________________ □ Deceased – Age ____________________

Major health problems and/or cause of death?

Do you have any brothers?

How many? □ Alive – Ages _______________________ □ Deceased – Ages ___________________

Major health problems and/or cause of death?

Do you have any sisters?

How many? □ Alive – Ages _______________________ □ Deceased – Ages ___________________

Major health problems and/or cause of death?

If you served in the military:

Were you ill while in the military? □ Yes □ No What was the nature of the illness?

Did you serve overseas? □ Yes □ No If yes, where & when?

REVIEW OF SYSTEMS		
Please check any of the following symptoms or problems you are currently experiencing. If the problem has been resolved, leave it blank. If you are unsure, place a question mark (?) by the medical issue.		
Constitutional	**Neurological**	**Bowel**
□ Fever □Yes □No	□ Seizures □Yes □No	□ Constipation □Yes □No
□ Weight loss □Yes □No	□ Headaches □Yes □No	□ Diarrhea □Yes □No
□ Weight gain □Yes □No	□ Loss of alertness □Yes □No	□ Blood/bleeding □Yes □No
□ Night sweats □Yes □No	□ Memory loss □Yes □No	□ Pain □Yes □No
□ Change in sleeping habits? □Yes □No	□ Weakness □Yes □No	□ Nausea □Yes □No
□ Hot/cold intolerance? □Yes □No	□ Numbness □Yes □No	□ Vomiting □Yes □No
Throat/Mouth	**Nose**	**Allergy/Lymphatic**
□ Sores □Yes □No	□ Smelling loss □Yes □No	□ Seasonal allergies □Yes □No
□ Unusual tastes □Yes □No	□ Unusual smells □Yes □No	□ Runny nose □Yes □No
□ Tongue swelling □Yes □No	□ Bleeding □Yes □No	□ Lymph node swelling/lumps □Yes □No
□ Teeth changes □Yes □No	□ Stuffiness □Yes □No	
Skin	**Eyes**	**Abdomen**
□ Rash □Yes □No	□ Vision change □Yes □No	□ Pain □Yes □No
□ Swelling □Yes □No	□ Eye pain □Yes □No	□ Cramping □Yes □No
□ Sores □Yes □No	□ Double vision □Yes □No	□ Masses □Yes □No
Psychological	**GYN/OB**	**Cardiovascular**
□ Behavior change □Yes □No	□ Change in menstrual habits □Yes □No	□ Chest pain □Yes □No
□ Personality change □Yes □No	□ Menses began age__________	□ Palpitations □Yes □No
□ Anxiety □Yes □No	□ Miscarriages □Yes □No	□ Lightheadedness □Yes □No
□ Aggressiveness □Yes □No	□ Menopause □Yes □No	□ Easy bruising □Yes □No
□ Suicidal thoughts □Yes □No	□ Contraception/birth control method ____________________________	□ Anemia □Yes □No
Urinary	**Musculoskeletal**	**Chest**
□ Change in habits □Yes □No	□ Joint pain □Yes □No	□ Shortness of breath □Yes □No
□ Smell □Yes □No	□ Joint swelling □Yes □No	□ Cough □Yes □No
□ Blood/bleeding □Yes □No	□ Low back pain □Yes □No	□ Blood/change in sputum □Yes □No
□ Urination at night □Yes □No	□ Neck pain □Yes □No	□ Wheezing □Yes □No
How many times______________	□ Muscle pain □Yes □No	□ Painful breathing □Yes □No
□ Painful urination □Yes □No	□ Cramps □Yes □No	□ Breast changes/mass □Yes □No
□ Sexual problems □Yes □No	□ Arthritis □Yes □No	□ Nipple discharge □Yes □No

Patient Signature ______________________________ **Date** ______________________________

We appreciate your cooperation in completing this form for your physician.

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