AMARILLO DIAGNOSTIC CLINIC, P.A.

PATIENT QUESTIONNAIRE
KARLENE REID, M.D.

Dear Patient:

Please answer all questions to the best of your ability. All the information is kept in strictest confidence and is for your physicians use in assessing your total health care needs. If you have any reservations, please feel free to discuss after leaving the question blank. PLEASE PRINT. Thank you very much!

PATIENT'S FULL NAME:_____

PERSONAL PHYSICIAN_____

DATE:_____

CHIEF COMPLAINTS: (List the problems about which you came to see the doctor)

1._____

_____

2._____

_____

REVIEW OF SYSTEMS

List all prior operations you have had:

_____ DATE:_____
_____ DATE:_____
_____ DATE:_____
_____ DATE:_____
_____ DATE:_____
_____ DATE:_____

List any major or disabling injuries you have sustained:

_____ DATE:_____
_____ DATE:_____
_____ DATE:_____

List any allergies you have to foods, inhaled pollens or medications:_____

_____

_____

Do you have any of the following conditions? If yes, for how long?

1. Diabetes_____
2. High Blood Pressure_____
3. Kidney Disease_____
4. Heart Disease_____
5. Ulcer Disease_____
6. Lung Disease (Emphysema, Asthma, etc.)

_____

Have you ever been hospitalized for anything other than operations, injuries or childbirth?_____
If yes, please list the hospitalizations and give the date and diagnosis if known:

_____ DATE:_____

_____ DATE:_____

_____ DATE:_____

Has your appetite recently changed?_____If yes, in what way?_____

(Please circle YES or NO if the question is appropriate)

Have you lost or gained weight?	**YES**	**NO**
Do you have problems with fever?	**YES**	**NO**
Do you ever sweat at night badly enough to soak your sheets or nightclothes?	**YES**	**NO**
SKIN – Do you have any of the following:		
Recurrent rash or eruptions?	**YES**	**NO**
Change in skin coloration?	**YES**	**NO**
Recurrent itching?	**YES**	**NO**
Recent change in hair distribution?	**YES**	**NO**
HEAD – Do you have any of the following:		
Recurrent severe headaches?	**YES**	**NO**
Recurrent significant double vision or change in visual acuity?	**YES**	**NO**
Recurrent ear discharge or severe ringing?	**YES**	**NO**
Recurrent nosebleeds or severe sinus pain?	**YES**	**NO**
Recurrent bleeding from the gums, dental abscesses, sore tongue or mouth ulcers?	**YES**	**NO**
Recurrent sore throats or difficulty in swallowing or speaking?	**YES**	**NO**
White plaque on the tongue, gums or throat?	**YES**	**NO**
ENDOCRINE- Do you have any of the following:		
Recent swelling in the neck?	**YES**	**NO**
Recent change in breast tissue or any nipple discharge?	**YES**	**NO**
Change in tolerance to heat or cold?	**YES**	**NO**
Excessive thirst or hunger?	**YES**	**NO**
RESPIRATORY – Do you have any of the following:		
Discomfort in the chest?	**YES**	**NO**
Difficulty breathing?	**YES**	**NO**
Unpleasant awareness of breathing?	**YES**	**NO**
Recurrent significant cough, productive cough, any history of coughing up blood, any previous abnormal x-rays?	**YES**	**NO**
CARDIAC – Do you have any of the following:		
Distress in the chest with exertion or after eating?	**YES**	**NO**

Shortness of breath?	**YES**	**NO**
Inability to sleep on less than 2 pillows?	**YES**	**NO**
Getting up at night more than 2 or 3 times to urinate?	**YES**	**NO**
Marked change in exercise capacity, history of hypertension?	**YES**	**NO**

HEMATOLOGIC – Do you have any of the following:

Tendency to bruise or bleed easily?	**YES**	**NO**
History of significant transfusions required during surgery?	**YES**	**NO**
History of recurrent anemia?	**YES**	**NO**
History of lymph gland swelling?	**YES**	**NO**

GASTROINTESTINAL– Do you have any of the following:

Recent change in digestion?	**YES**	**NO**
Pain in relationship to eating?	**YES**	**NO**
Increased abdominal gas?	**YES**	**NO**
Nausea and vomiting?	**YES**	**NO**
Change in bowel habits?	**YES**	**NO**
Change in stool color?	**YES**	**NO**
Painful defecation?	**YES**	**NO**
Vomiting up of blood or blood in the stools?	**YES**	**NO**
Yellow jaundice?	**YES**	**NO**

GENITOURINARY– Do you have any of the following:

Pain with urination?	**YES**	**NO**
Increasing frequency of urination?	**YES**	**NO**
History of kidney stones?	**YES**	**NO**
Blood in the urine?	**YES**	**NO**
Changing amounts of urination?	**YES**	**NO**
Swelling in the face of hands?	**YES**	**NO**
Change in the force of the urinary stream?	**YES**	**NO**

TO BE ANSWERED BY WOMEN ONLY:

Have you had a change in menses?	**YES**	**NO**
Any discharge from the breasts?	**YES**	**NO**

Please list the numbers of times you have been pregnant, miscarriages and age of your children:

_____

_____

NEUROMUSCULAR– Do you have any of the following:

Do you have significant nervousness?	**YES**	**NO**
Insomnia?	**YES**	**NO**
Drowsiness?	**YES**	**NO**
Tremors?	**YES**	**NO**
Convulsions?	**YES**	**NO**
Paralysis?	**YES**	**NO**
Seizures?	**YES**	**NO**
Fits?	**YES**	**NO**
Recurrent extremity pain or weakness?	**YES**	**NO**

PSYCHOLOGICAL HISTORY

Have you ever been hospitalized or treated for a psychiatric problem of any kind? **YES** **NO**

If yes, please list the date and nature of the problem:_____

_____

Do you have a problem with nervousness, anxiety, or depression? **YES NO**
Do you have problems sleeping? **YES NO**

If so, what kind of problems?_____

_____

FAMILY HISTORY
Please list the current age (or age at time of death) of your mother, father and any brothers or sisters and please list any diseases which tend to "run in your family" (especially high blood pressure, diabetes, heart disease, cancer, gout, asthma, stomach ulcer, arthritis, allergies, epilepsy, tuberculosis, cystic fibrosis, or muscle disease).

_____

_____

PLEASE LIST ALL CURRENT MEDICATIONS YOU ARE TAKING AND HOW LONG YOU'VE TAKEN THEM

MEDICATION	DOSAGE	HOW LONG

SOCIAL HISTORY
Do you smoke cigarettes or use tobacco in any form? **YES NO**

If so, how much and for how long have you used tobacco? _____

Do you drink alcohol? If so, how many drinks or glasses of wine, cans of beer per week?_____
Do you use or have you ever used any recreational drugs? **YES NO**

If so, which ones and how often?_____

Have you ever been treated for a venereal disease? If so, when?_____ **YES NO**

Are you currently employed? If so, what kind of work do you do?_____ **YES NO**

Do you live alone? If not, with whom do you live?_____ **YES NO**

Do you have children at home? **YES NO**
Have you ever been refused induction in the military service
or been denied insurance because of medical abnormalities? **YES NO**
If you served in the military:
(1) Were you ill while in the military? **YES NO**

If so, what was the nature of the illness?_____

(2) Did you serve overseas? **YES NO**

If you have traveled out of the Amarillo area in the past year, please list the places where you have been:

_____

Please list all pets or any other animals which you may have been in contact with in the past year:

_____

_____

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