

SUMMIT MEDICAL GROUP
Health Information Questionnaire

Today's Date _____ **Which doctor are you seeing today?** _____

Patient's Name: _____ **Date of Birth:** _____

Parmacy Name: _____ **Telephone #:** _____

What medications are you currently taking?

Are you allergic to any medications? _____ If yes, what medications? _____

What type of reaction did you have to this medication? _____

Are you currently pregnant or nursing? _____

What is the reason for your visit today? _____

Please check any symptoms below that you are currently experiencing:

• General

___ Recent Weight gain/loss?
Amount _____

___ Fatigue/Lack of energy

___ Fever/Night sweats

• Ears/Eyes/Nose

___ Ringing in ears or hearing loss

___ Loss of vision

___ Double or blurred vision

___ Sinus drainage or congestion

• Mouth/Throat

___ Sores in mouth

___ Hoarseness

___ Difficulty or painful
swallowing

___ Swollen glands

• Breasts

___ Pain

___ Lump

___ Discharge from Nipple

• Heart and Lungs

___ Pain in chest

___ Irregular/Fluttering heart beat

___ Shortness of breath

___ Short of breath when lying flat

___ Swollen legs/feet

___ Cough

___ Coughing of Blood

___ Wheezing

• Stomach/Intestines

___ Frequent heartburn

___ Nausea

___ Vomiting of Blood

___ Constipation

___ Persistent Diarrhea

___ Red blood in stools

___ Black or tarry stools

• Kidney/Bladder

___ Painful urination

___ Discharge from penis/vagina

___ Blood in Urine

___ Getting up at night to urinate

How many times? _____

• Skin

___ Rash

___ Sores/Moles that won't heal

___ Dark or enlarging moles

• Muscles/Joints/Bones

___ Morning stiffness

Minutes _____

Hours _____

___ Joint pain or swelling

Where? _____

___ Muscle weakness/Tenderness

• Nervous System

___ Frequent headaches

___ Sensitivity to pain in hands or feet

___ Memory loss

___ Difficulty walking or with
balance/coordination

• Endocrine

___ Heat or cold intolerance

___ Excessive thirst/urination

___ Periods regular

Yes ___ No ___

Last Menstrual Period: _____

Age when periods stopped _____

Last Pap: _____

Contraception: _____

• Habits

Do you use tobacco products?

Yes ___ No ___ Past _____

Cigarettes per day _____

How many years have or did you
use tobacco? _____

Drink more than 2 alcoholic
beverages per day?

Yes ___ No ___

Cups of coffee per day? _____

Use seatbelt regularly?

Yes ___ No ___

Do you use drugs for reasons that are not
medical? If so, please list:

(See additional questions on back of form)

Past History:

Have you been treated for any of the following conditions in the past? If so, please list approximate dates of treatment and treating physicians.

CONDITION:	APPROXIMATE DATES OF TREATMENTS:	TREATING PHYSICIAN:
Psychological:		
Diabetes		
GI Disease		
Liver Disease		
Heart Disease		
Phlebitis		
Anemia		
Arthritis		
Blood Disease		
Thyroid Disease		
Weight		
Cholesterol		
Seizures		
High blood pressure		
Stroke		
Genital/Urinary Disease		
Serious Accident		
Surgeries:		
Hospitalizations:		

Marital Status: _____ Number of Children: _____

Family History:

Have any members of your immediate family (parents, siblings, grandparents, children) ever had:

Breast Cancer? _____ If so, whom? _____

Colon Cancer? _____ If so, whom? _____

Other types of cancer? _____ If so, whom? _____

High blood pressure? _____ If so, whom? _____

Stroke? _____ If so, whom? _____

Heart problems? _____ If so, whom? _____

Diabetes? _____ If so, whom? _____

Please list any other relevant information or questions you may have for the physician today:
