SUMMIT MEDICAL GROUP
Health Information Questionnaire

Today's Date: _____ Primary Care Physician: _____ MRN: _____

Patient's Name: _____ Date of Birth: _____ Sex: ❑ M ❑ F

Preferred Pharmacy: _____ Telephone Number: _____

What is the reason for your visit today? _____

What medications are you currently taking? (Attach list if necessary)

Medication:	Prescribed by:	Do you need a refill today?

Are you allergic to any medications? ❑ Yes ❑ No If yes, what medication? _____

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

Are you currently pregnant or nursing? _____

Please check any symptoms below that you are currently experiencing:

Constitutional:
____ Fever/Chills
____ Feeling poorly
____ Feeling tired
____ Recent weight gain/loss
____ Night sweats

Eyes:
____ Eye pain
____ Red eyes/Discharge
____ Vision changes
____ Dry eyes
____ Itchy eyes

ENT:
____ Earache
____ Sore throat
____ Nasal congestion/discharge
____ Nosebleeds
____ Hoarseness
____ Hearing Loss

Cardiovascular:
____ Chest pain
____ Irregular heart beats
____ Lower extremity edema
____ Leg cramps
____ Pain with exercise
____ Slow heart rate
____ Fast heart rate

Respiratory:
____ Shortness of breath
____ Shortness of breath during exertion
____ Cough
____ Wheezing
____ Shortness of breath with lying down/at night

Gastrointestinal:
____ Nausea and/or Vomiting
____ Abdominal pain
____ Diarrhea
____ Heartburn
____ Constipation

Genitourinary:
____ Trouble swallowing
____ Dark or bloody stool
____ Pain with urination
____ Frequency/Urgency of urination
____ Night time urination
____ Hesitancy
____ Incontinence (loss of urine control)
____ Blood in urine
____ Genital lesion
____ Difficulty with menstrual periods (females)
____ Erectile dysfunction (males)

Musculoskeletal:
____ Joint pain
____ Muscle pain
____ Joint swelling
____ Joint stiffness
____ Limb pain/swelling
____ Muscle cramps/weakness

Integumentary:
____ Skin rash
____ Itching
____ Skin lesions
____ Change in a mole
____ Breast pain/lump
____ Wound/Unusual growth on the skin

Neurological:
____ Headache
____ Dizziness
____ Mental changes
____ Fainting
____ Limb weakness
____ Difficulty walking
____ Numbness
____ Tremor
____ Radiating pain

Psychiatric:
____ Anxiety
____ Depression
____ Suicidal or homicidal thoughts
____ Personality changes/Irritability
____ Sleep disturbances

Endocrine:
____ Excessive thirst/urination
____ Drooping of eyelid
____ Hot or cold intolerance
____ Hair loss
____ Generalized weakness

Blood/Lymph:
____ Easy bruising/bleeding
____ Swollen glands

Social History:

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 seat belt regularly?
❑ Yes ❑ No
Do you use drugs for reasons that are not medical? If so, please list:
_____
_____
_____

(See additional questions, on back of form.)

Patient Name:_____ Date of Birth: _____ MRN:_____

Marital Status: ❑ Single ❑ Married ❑ Divorced Number of Children: _____ Number of pregnancies: _____

Family History:

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

Breast Cancer: ❑ Yes ❑ No If so, whom? _____
Colon Cancer: ❑ Yes ❑ No If so, whom? _____
Other types of cancer: ❑ Yes ❑ No If so, whom? _____
High blood pressure: ❑ Yes ❑ No If so, whom? _____
Stroke: ❑ Yes ❑ No If so, whom? _____
Heart problems: ❑ Yes ❑ No If so, whom? _____
Diabetes: ❑ Yes ❑ No If so, whom? _____

Past Medical History:

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

Condition:	Approximate Dates of Treatment:	Treating Physician:
Anemia		
Arthritis		
Blood Disease		
Cancer		
Cholesterol		
Diabetes		
GI Disease		
Genital/Urinary Disease		
Heart Disease		
High blood pressure		
Liver Disease		
Lung disease/Asthma		
Phlebitis		
Psychological		
Seizures		
Stroke		
Thyroid Disease		
Weight		
Serious Accident:		
Surgeries:		
Hospitalizations:		

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

_____

_____

_____