SUMMIT MEDICAL GROUP
Health Information Questionnaire

Today's Date:__________________Primary Care Physician:____MRN: ____________

Patient's Name:____Date of Birth:_______________Sex: q M q F

Preferred Pharmacy:_______________________________________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? q Yes q 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?
q Yes q No q Past
Cigarettes per day? __________
How many years have or did you use tobacco? __________
Drink more than 2 alcoholic beverages per day?
q Yes q No
Cups of coffee per day? ___________
Use seat belt regularly?
q Yes q 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: q Single q Married q Divorced Number of Children: ______ Number of pregnancies: ______

Family History:

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

Breast Cancer: q Yes q No If so, whom? ____

Colon Cancer: q Yes q No If so, whom? ____

Other types of cancer: q Yes q No If so, whom? ____

High blood pressure: q Yes q No If so, whom? ____

Stroke: q Yes q No If so, whom? ____

Heart problems: q Yes q No If so, whom? ____

Diabetes: q Yes q 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:

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