Groskopp and Ryland

Rogue Valley Physicians, PC

PATIENT QUESTIONNAIRE

Name _____**Date**:_____

DOB:_____Age:_____Nickname(if preferred): _____

Check all applicable spaces and give additional information where indicated.

Occupation: _____

Drug Allergies:

____ Penicillin
____ Codeine
____ Aspirin
____ Tetanus
____ Morphine
____ Sulfa
____ Tetracycline
Other_____

Current Medications:

Drug Name Frequency

_____
_____
_____
_____

Past Medications:

____ Birth Control
____ Thyroid
____ Cortisone
____ Insulin
____ Heart medication
____ Water pills
____ Other_____

Past Medical History:

____ Diabetes
____ High blood pressure
____ Thyroid disease
____ Goiter
____ Cancer: Type:_____
____ Leukemia
____ Blood disease
____ Anemia
____ Blood transfusion
____ Arthritis
____ Skin disease
____ Gonorrhea
____ Hives
____ Alcoholism
____ Sexually transmitted disease

____ Heart disease
____ Heart attack
____ Congestive failure
____ Rheumatic fever
____ Heart murmur
____ Irregular rhythm
____ Liver disease
____ Gout
____ Hepatitis
____ Lung disease
____ Asthma
____ Bronchitis
____ Emphysema
____ Pneumonia
____ Psychiatric problem

____ Bowel disease
____ Colitis
____ Stomach disease
____ Ulcers
____ Tuberculosis
____ Gallbladder
____ Kidney disease
____ Kidney stones
____ Bladder trouble
____ Phlebitis
____ Blood clots
____ Concussion
____ Seizure
____ Meningitis
____ Depression

____ Other serious illness / condition_____

Surgery	**Year**	**Other Hospitalizations**	**Year**
____ Appendix	_____	_____	_____
____ Hernia	_____		
____ Hysterectomy	_____	_____	_____
____ Gallbladder	_____		
____ Orthopedic	_____	_____	_____
____ Heart/lung	_____		
____ Tonsillectomy	_____	_____	_____
____ Gastric Bypass	_____		

Family History	**Relationship**	**Personal Habits**	**Amount per day**
____ Diabetes	_____	____ Alcohol	_____
____ Heart Disease	_____	____ Tobacco	_____
____ Tuberculosis	_____	____ Coffee	_____
____ Hypertension	_____	____ Marijuana	_____
____ Epilepsy	_____	____ Street drugs	_____
____ Asthma	_____	____ Other	_____
____ Cancer	_____		
____ Stroke	_____		
____ Dementia	_____		

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Systems Review:

Head & Neck:
____ Frequent headaches
____ Neck pain
____ Lumps or swelling
____ Difficulty swallowing

Eyes:
____ Blurred vision
____ Double vision
____ Seeing halos
____ Eye pain
____ Watering
____ Itching
____ Wear eyeglasses
____ Date of last eye exam

Ears:
____ Difficulty Hearing
____ Buzzing or ringing
____ Earaches
____ Frequent infections
____ Drainage
____ Use hearing aid

Mouth:
____ Dental Problems
____ Frequent Sores
____ Swelling or Lumps

Nose & Throat:
____ Frequent nosebleeds
____ Sinus problems
____ Nasal congestion
____ Frequent sore throats
____ Chronic hoarse voice

Skin:
____ Rashes
____ Sores
____ Change in mole
____ Lumps or swelling
____ Bleed easily
____ Bruise easily
____ Itching

Neurological:
____ Seizures
____ Numbness
____ Trembling
____ Fainting spells
____ Change in handwriting
____ Memory loss

Cardiovascular:
____ Chest pains
____ Dizziness
____ Heart “racing”
____ Shortness of breath
____ Swollen ankles
____ Leg cramps
____ Irregular pulses
____ Poor circulation

Respiratory:
____ Wheezing
____ Frequent cough
____ Cough up phlegm
____ Cough up blood
____ Excessive sweating
____ Sit up to sleep
____ Trouble breathing

Digestive:
____ Frequent indigestion
____ Heartburn
____ Frequent belching
____ Bloated stomach
____ Nausea or vomiting
____ Spit up blood
____ Constipation
____ Diarrhea
____ Black stools
____ Hemorrhoids
____ Rectal pain
____ Rectal bleeding
____ Change in stools

Urinary:
____ Frequency
____ Urgency
____ Burning or pain
____ Trouble starting
____ Wet pants or bed
____ Dark urine
____ Bloody urine

Musculoskeletal:
____ Joint pains
____ Aching muscles
____ Swollen joints
____ Weakness
____ Tingling
____ Non ambulatory

General:
____ Hot or cold
____ Poor Appetite
____ Always tired
____ Trouble sleeping
____ Lack of exercise
____ Always thirsty
____ Cries often
____ Depressed
____ Hopeless outlook
____ Easliy angered / Lose temper
____ Considered suicide
____ Weight loss
____ Weight gain
____ Sexual difficulty

Males:
____ Lumps on testicles
____ Painful testicles
____ Prostate problems
____ Penile discharge
____ Penile burning

Females:
____ Irregular periods
____ Abnormal bleeding
____ Vaginal discharge
____ Severe cramps
____ Hot flashes
____ Menopause
____ Post-Menopause
____ Breast lumps
____ Previous C-Section
____ Previous Abortion
____ # Pregnancies
____ # Living Children
____ Date of last period
____ Date of last Pap

Other Concerns / Miscellaneous

_____

_____

_____

_____

_____

Signed:_____ _____
Patient or Representative Date