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MEDICAL QUESTIONNAIRE

It is our goal to develop the best understanding possible of your current condition. Thank you for taking the time to fill out this questionnaire. Complete the pages to the best of your ability; ask your family; spend a few days trying to remember everything; bring old medical records to the first visit, if possible. Although some of the questions are personal, they are asked for medical reasons and will be kept in the strictest confidence. We appreciate your help in this effort.

—Leslie Campbell, MD

Name: _____ Date: _____

Age: _____ Date of birth: _____ Place of Birth: _____

Marital status: Single Partner Married Divorced Remarried Widowed

Occupation: _____

Do you have a: Power of attorney Yes No
 Living will Yes No
 Advanced directives Yes No
 Organ Donor Yes No
 (If not a donor, would you like to be?) Yes No

FAMILY HISTORY:

	Age	Living	Deceased	Medical problems
Mother	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Grandmother	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Grandfather	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Father	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Grandmother	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Grandfather	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Siblings				
1	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
2	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
3	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
4	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
5	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
6	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Children				
1	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
2	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
3	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
4	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Relatives				
1	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
2	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
3	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
4	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

MEDICAL HISTORY:

1. Medicine allergies: (describe the reaction)

2. Childhood illness:

3. Surgeries: (look at yourself for scars)

4. List any medical illness you have had or anything you've seen a doctor for:

5. Do you have diabetes? Yes No

6. Do you have high blood pressure? Yes No

7. Have you had a stroke? Yes No

8. What medicines are you taking now?

9. Do you take vitamins? Yes No

10. Do you use "over the counter" medicines? Yes No

11. Are you taking herbal supplements? Yes No

12. What medicines have you been treated with in the past?

13. Do you wear glasses? Yes No
 For distance? Yes No
 For reading? Yes No
14. Do you wear hearing aids? Yes No
15. Do you have any hardware that is implanted in you? Yes No
16. Have you ever had a blood transfusion? Yes No
17. Have you ever had a sexually transmitted disease? Yes No
18. Have you had a kidney stone? Yes No
19. Have you known anyone with tuberculosis? Yes No
20. What have you been to emergency rooms for?

21. Women:

How many times have you been pregnant?

How many children did you have?

Did you have miscarriages or abortions?

Yes No

Were your pregnancies normal?

Yes No

Was the delivery normal?

Yes No

When was your last menstrual period?

22. Tests:

Has your cholesterol been checked?

Yes No

Have you had a stress test?

Yes No

Have you had xrays?

Yes No

Have you had an EKG?

Yes No

Have you had any "scans"?

Yes No

PREVENTIVE MEDICINE ISSUES:

23. When did you last see a doctor?

24. What vaccinations have you received and when?

25. Do you see a dentist regularly?

Yes No

When was the last visit?

26. Have you been evaluated for colon cancer? Yes No
27. Have you been evaluated for prostate cancer? Yes No
28. Women: Do you have regular pap smears? Yes No
 Were any abnormal? Yes No
 When was your last pap smear? _____
29. Women: Have you had a mammogram? Yes No
 Has any mammogram been abnormal? Yes No
30. Describe the average amount of exercise you do? _____
 What is the most strenuous thing you have done recently? _____
 How far can you walk without stopping? _____
 Can you walk up hills? Yes No
 Do you experience any unusual symptoms with exercise? Yes No
 If so, what?

SOCIAL ISSUES:

31. Did you ever smoke? Yes No
32. Did you ever use any tobacco products? Yes No
33. Did you ever drink alcohol products? Yes No
34. Do you have pets? Yes No
 What kind? _____

35. Travel:
 If you have traveled outside the continental U.S. please list the countries and the dates?

- Did you take any special medications while you were there? Yes No
- Were you well during the trips? Yes No
- Did you get sick at any time? Yes No

DO YOU HAVE...?

- General
 - Fever Yes No
 - Weight changes Yes No
 - Fatigue Yes No
- Sleeping pattern
 - Do you wake up rested Yes No
 - Do you need naps Yes No
 - Bleeding tendencies Yes No
- Head and neck
 - Headaches Yes No
 - Vision problems Yes No
 - Change in speech Yes No
 - Memory problems Yes No
 - Neck pain Yes No
- Chest
 - Chest pain or discomfort Yes No
 - Palpitations Yes No
 - Passed out Yes No
 - Difficulty breathing Yes No
 - Wheezing Yes No
 - Cough Yes No
- Abdomen/Gastrointestinal
 - Indigestion Yes No
 - Heart burn Yes No
 - Nausea Yes No
 - Vomiting Yes No
 - Pain Yes No
- Back
 - Upper back pain Yes No
 - Lower back pain Yes No
- Legs and arms
 - Weakness in any arm or leg Yes No
 - Swelling in either leg Yes No
 - Pain in calves, thighs, or buttocks Yes No
- Joint pain or discomfort in
 - Hands Yes No
 - Wrists Yes No
 - Elbows Yes No
 - Shoulders Yes No
 - Hips Yes No
 - Knees Yes No
 - Feet/Ankles Yes No
- Reproductive
 - Impotence Yes No
 - Pain during intercourse Yes No
 - Genital bleeding Yes No
 - Difficulty urinating Yes No
 - Painful urination Yes No
 - Difficulty initiating urination Yes No
 - Dribbling or incontinence Yes No
- Mental health
 - Have you been depressed Yes No
 - Do you feel emotionally well Yes No

MISCELLANEOUS:

Have you been exposed to hazardous or toxic chemicals or radiation? Yes No

Are you allergic to shellfish? Yes No

Describe anything unusual not listed here, even if you think it's insignificant: