Atlantic Internal Medicine

Adult

Patient Questionnaire

Full Name	Age	Date & Place of Birth	Today's Date

Education	Age of completion	Occupation	☐ Live by Self ☐ Live with Family ☐ Other (Specify)	☐ Marital Status _____ #Children _____
Reason for Today's Visit ▶				

PLEASE INDICATE ANY ILLNESS OR CONDITION THAT YOU HAVE HAD

☐ Diabetes	☐ Depression	☐ Liver Disease	☐ Arthritis	☐ STDs	☐ Asthma or COPD(Emphysema)
☐ High Blood Pressure	☐ Anxiety	☐ Migraines	☐ Gout	☐ IBS	☐ Eczema or other skin disorder
☐ High Cholesterol	☐ Thyroid Disease	☐ Seizures	☐ Back Pain/Sciatica	☐ Alcoholism	☐ Cancer(Specify)_____
☐ Heart Disease	☐ GERD/Ulcers	☐ Cataracts	☐ Kidney Stones	☐ Tobacco Abuse	☐ Other_____
☐ Stroke	☐ Kidney Disease	☐ Glaucoma	☐ Recurrent UTI	☐ Drug Abuse	☐ Other_____

FAMILY HISTORY

Family Member	Diabetes	Cancer	Heart Disease	Stroke	High Blood Pressure	High Cholesterol	Asthma	Anxiety	Depression	Liver Disease	Kidney Disease	Other Please Indicate
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Brother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Son	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Daughter	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Grandparent	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Surgical History

Type of Operation	Date

CURRENT MEDICATIONS - Both Prescriptions & Over The Counter

Name	Dosage	Name	Dosage

Continue on Back if Needed

VACCINES

Indicate disease against which you have been immunized

☐ Tetanus ☐ Pneumovax ☐ Meningitis ☐ Shingles

Other (Describe) _____

Date of last known Tetanus Shot _____

FEMALE HISTORY

LMP			
Number of Pregnacies			
Contraception Used	☐ Yes	☐ No	Type _____
Menstrual Problems	☐ Yes	☐ No	
Last Pap Test	Date		
Last Mammogram Last	Date		
Bone Density	Date		
Last Colonoscopy	Date		
Any Abnormal Paps	☐ Yes	☐ No	

Male History

Last Prostate Check	Date
Last PSA Reading	Date
Last Colonoscopy	Date

MEDICATION ALLERGIES:

EXERCISE HABITS Walking Sports Other

SLEEP HABITS Bed Time Awake At

	YES	NO	Daily Amount
Do you currently use tobacco?	☐	☐	
Did you use tobacco in the past?	☐	☐	
Do you drink coffee or tea?	☐	☐	
Do you drink alcohol?	☐	☐	