PETER A. DABROWSKI, MD

Diplomate Board of Internal Medicine

DATE:_____

PATIENT'S NAME: _____

CLINIC QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS HONESTLY BY CIRCLING YES OR NO

ARE YOU BOTHERED BY (IN THE PAST OR PRESENT)

HEARTBURN/INDIGESTION	YES	NO	CONFUSION	YES	NO
NAUSEA/VOMITING	YES	NO	SINUS	YES	NO
NIGHT SWEATS	YES	NO	DIARRHEA	YES	NO
SKIN PROBLEMS	YES	NO	PERSISTENT VOMITING/DIARRHEA >3 DAYS	YES	NO
HAY FEVER	YES	NO	CONSTIPATION	YES	NO
HEARING LOSS	YES	NO	CHANGE IN BOWEL HABITS	YES	NO
NECK LUMPS	YES	NO	BLOOD IN STOOLS	YES	NO
COUGH	YES	NO	BLACK STOOLS	YES	NO
COUGH UP BLOOD	YES	NO	HEMORRHOIDS	YES	NO
SHORTNESS OF BREATH	YES	NO	BURNING WITH URINE	YES	NO
HEART MURMUR	YES	NO	FREQUENCY OF URINATION	YES	NO
CHEST PAIN	YES	NO	BLOOD IN URINE	YES	NO
PALPITATIONS	YES	NO	JOINT/BONE PAIN	YES	NO
FEVER/CHILLS	YES	NO	BACKACHE	YES	NO
HEART ATTACK	YES	NO	WEAKNESS/TINGLING IN ARMS OR LEGS	YES	NO
SWELLING OF LEGS/FEET	YES	NO	LOSS OF CONSCIOUSNESS	YES	NO
ABDOMINAL PAIN	YES	NO	SEIZURES	YES	NO
HEADACHES	YES	NO	STROKES	YES	NO
VISUAL PROBLEMS	YES	NO	ANEMIA	YES	NO
EYE PAIN	YES	NO	CANCER	YES	NO
GALLBLADDER	YES	NO	DIFFICULTY BATHING	YES	NO
DIABETES	YES	NO	DIFFICULTY WALKING	YES	NO
WEIGHT LOSS	YES	NO	DIFFICULTY DRESSING	YES	NO
HIGH BLOOD PRESSURE	YES	NO	DIFFICULTY CHEWING/SWALLOWING	YES	NO
HIGH TRIGLYCERIDES	YES	NO	DIFFICULTY EATING	YES	NO
HIGH CHOLESTEROL	YES	NO	DIFFICULTY SPEAKING	YES	NO
IMPAIRED IMMUNE SYSTEM	YES	NO	DIFFICULTY UNDERSTANDING	YES	NO
KIDNEY DISEASE	YES	NO	DO YOU WEAR YOUR SEATBELT	YES	NO
UNINTENTIONAL WT LOSS >10 LBS	YES	NO	DO YOU TEXT AND DRIVE	YES	NO
ANOREXIA/BULIMIA	YES	NO	ANY MENTAL TRAUMA	YES	NO
OVERWEIGHT OR UNDERWEIGHT	YES	NO	ANY MEDICAL TRAUMA	YES	NO

MEN			**WOMEN**		
POOR URINE STREAM	YES	NO	IRREGULAR PERIODS	YES	NO
PROSTATE TROUBLE	YES	NO	VAGINAL DISCHARGE	YES	NO
DIFFICULTY WITH ERECTION	YES	NO	ABNORMAL VAGINAL BLEEDING	YES	NO
BURNING/DISCHARGE FROM PENIS	YES	NO	LUMPS IN BREAST	YES	NO
			DO YOU PERFORM SELF BREAST EXAMS?	YES	NO
			LAST PAP TEST DATE:		_____
			NUMBER OF PREGNANCIES:		_____
			LAST MAMOGRAM: DATE:		_____

SEXUAL ORIENTATION STRAIGHT/HETEROSEXUAL BISEXUAL GAY LESBIAN

ARE YOU SEXUALLY ACTIVE YES NO

ARE YOU AT RISK FOR SEXUALLY TRANSMITTED INFECTIONS (STD's) YES NO

RECENT COLONOSCOPY _____ RECENT EYE EXAM _____ RECENT BONE DENSITY _____

PATIENT'S NAME: _____ DATE: _____

MEDICATIONS

PLEASE CHECK ALL CURRENT AND FREQUENTLY TAKEN MEDICATIONS (INCLUDING OVER THE COUNTER PRODUCTS)

- ☐ ANALGESICS (PAIN MEDICATION)
- ☐ ANTIARTHRITICS
- ☐ SEIZURE MEDICATIONS
- ☐ BLOOD PRESSURE MEDICATIONS
- ☐ DIURETICS (WATER PILLS)
- ☐ EYE MEDICATIONS
- ☐ OTHER
- ☐ VITAMINS-MINERALS
- ☐ ANTACIDS
- ☐ ASTHMA MEDICATIONS
- ☐ ANTIDEPRESSANTS
- ☐ SEDATIVES –TRANQUILIZERS
- ☐ CHEMOTHERAPY
- ☐ CARDIAC MEDICATION
- ☐ ANTIBIOTICS
- ☐ DIABETES MEDICATIONS
- ☐ HORMONES
- ☐ BLOOD THINNERS
- ☐ BIRTH CONTROL PILLS

MEDICATION NAME	DOSE	FREQUENCY	COMMENTS

ANY OTHER SERIOUS ILLNESS OR INJURIES? YES NO PLEASE EXPLAIN HERE: _____

_____

_____

IMMUNIZATIONS

YES NO TETANUS DATE:_____

YES NO HEPATITIS B DATE:_____

YES NO PNEUMONIA DATE:_____

YES NO FLU DATE:_____

SOCIAL HISTORY

HAVE YOU EVER SMOKED? YES NO WHAT AGE DID YOU START? _____ HOW MANY YEARS? _____

DO YOU OR HAVE YOU EVER USED E-CIGARETTES/VAPE? YES NO

DO YOU STILL SMOKE? YES NO IF NO, AT WHAT AGE DID YOU QUIT? ____

IF STILL SMOKING, HOW MANY CIGARETTES PER DAY? ____ CIGARS PER DAY? ____ PIPES PER DAY? ____

DO YOU DRINK ALCOHOLIC BEVERAGES? YES NO ABOUT HOW MANY DRINKS DO YOU CONSUME PER WEEK? ____

HAVE YOU RECEIVED TREATMENT FOR A DRINKING PROBLEM? YES NO

HAVE YOU BEEN ADVISED TO STOP DRINKING? YES NO

HAVE YOU RECEIVED TREATMENT FOR A DRUG PROBLEM? YES NO

DO YOU EXERCISE? YES NO IF YES, HOW MANY TIMES PER WEEK? _____

TOXIC EXPOSURE? YES NO

SUN EXPOSURE? YES NO

HIV/STD? YES NO

HOW MANY CAFFEINATED BEVERAGES DO YOU CONSUME DAILY? _____

PATIENT'S NAME: _____ DATE: _____

FAMILY HISTORY

DO ANY OF YOUR BLOOD RELATIVES HAVE:

CANCER (TYPE: _____)	YES	NO	STROKE	YES	NO
HIGH BLOOD PRESSURE	YES	NO	KIDNEY OR BLADDER DISEASE	YES	NO
DIABETES	YES	NO	GLAUCOMA	YES	NO
ARTHIRITIS	YES	NO	LIVER DISEASE	YES	NO
EPILEPSY	YES	NO	COLITIS	YES	NO
ULCER DISEASE	YES	NO	ALLERGY OR ASTHMA	YES	NO
ANEMIA	YES	NO	TUBERCULOSIS	YES	NO
HEARING LOSS	YES	NO	EMPHYSEMA	YES	NO
HEREDITARY DISEASE	YES	NO	MENTAL ILLNESS	YES	NO
HEART DISEASE	YES	NO	OTHER		

CURRENT HEALTH STATUS

	AGE	GOOD	POOR	DECEASED	CAUSE OF DEATH
FATHER					
MOTHER					
BROTHER					
SISTER					
DAUGHTER/SON					
DAUGHTER/SON					
DAUGHTER/SON					

ALLERGIES

REACTIONS TO MATERIALS AT WORK	YES	NO	TREATMENT FOR ALLERGIC CONDITIONS	YES	NO
REACTIONS TO OTHER MATERIALS	YES	NO	DERMATITIS	YES	NO
REACTIONS TO ANIMALS	YES	NO	HIVES	YES	NO
REACTIONS TO MEDICINES OR FOOD	YES	NO	HAY FEVER	YES	NO

LIST MEDICATIONS YOU ARE ALLERGIC TO: _____

_____

HOSPITALIZATIONS AND SURGERY

DESCRIPTION	DATE