PennState Health
Milton S. Hershey Medical Center

PATIENT QUESTIONNAIRE

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient Signature: _____

Date: _____

Occupation: _____ If retired, previous occupation: _____

Please list below the names and addresses of any Physicians you would like to receive a copy of todays evaluation *(other than the physician who referred you.)*

Name	**Address** *(if known)*
_____	_____
_____	_____
_____	_____

What problem are you having that brought you here today?

_____

_____

Are you currently having any pain? Please circle a number below to rate your pain.

0 **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

No Pain → Moderate Pain → Severe Pain

Please list your medications below

Include aspirin, herbals, eye drops, vitamins and all over-the-counter medications

MEDICATION NAME	DOSE (HOW MANY MILLIGRAMS?)	FREQUENCY (HOW MANY TIMES PER DAY?)

Please list any allergies (medication/environmental/food)

ALLERGIC TO	TYPE OF REACTION

Please list any previous surgery

DATE (APPROXIMATE)	TYPE OF SURGERY	HOSPITAL

Do you smoke cigarettes? ☐ yes ☐ no If yes, how many packs per day:_____, How many years:_____

☐ quit smoking _____ years ago ☐ never smoked

Please check any other tobacco products you use: ☐ cigars ☐ pipe tobacco ☐ chew tobacco

Do you drink alcohol? ☐ yes ☐ no If yes, What type:_____, How often:_____

Do you use any recreational or street drugs? ☐ yes ☐ no If yes, what type:_____, How often:_____

Family Medical History

☐ Cancer ☐ COPD or Asthma ☐ Heart Disease ☐ High Blood Pressure or Stroke ☐ Kidney Disease ☐ Other

Medical History (please check all that apply to you now or in the past)

Cardiovascular:

Yes	No	
☐	☐	Rheumatic fever
☐	☐	Heart murmur
☐	☐	Palpitations
☐	☐	Irregular heart beat
☐	☐	Chest pain
☐	☐	Heart attack
☐	☐	High blood pressure
☐	☐	Heart failure
☐	☐	High cholesterol
☐	☐	Stroke/Mini stroke (TIA)
☐	☐	Blood clots (DVT)
☐	☐	Pulmonary emboli
☐	☐	Varicose veins
☐	☐	Pain in legs with walking
☐	☐	Bruising/bleeding tendency
☐	☐	Aneurysms

Respiratory:

Yes	No	
☐	☐	Asthma
☐	☐	Wheezing
☐	☐	Emphysema
☐	☐	COPD
☐	☐	Chronic cough
☐	☐	Tuberculosis
☐	☐	Sleep apnea (stop breathing during sleep)
☐	☐	Oxygen use
☐	☐	Lung cancer

Gastrointestinal:

Yes	No	
☐	☐	Stomach ulcers
☐	☐	Gastric reflux/heartburn
☐	☐	Hepatitis (specify A, B, C)
☐	☐	Liver disease
☐	☐	Blood in stool
☐	☐	Black (tarry) stool
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Change in bowel movements
☐	☐	Abdominal pain
☐	☐	Nausea/Vomiting
☐	☐	Crohns disease
☐	☐	Irritable bowel syndrome
☐	☐	Ulcerative colitis
☐	☐	Colon cancer

Genitourinary:

Yes	No	
☐	☐	Frequent urination
☐	☐	Nighttime urinary frequency
☐	☐	Burning with urination
☐	☐	Blood in urine
☐	☐	Lack of bladder control
☐	☐	Weak urine stream
☐	☐	Urinary tract infections
☐	☐	Kidney stones
☐	☐	Kidney failure
☐	☐	Enlarged prostate
☐	☐	Prostate cancer
☐	☐	Bladder cancer
☐	☐	Kidney cancer
☐	☐	Testicular cancer
☐	☐	Erectile Dysfunction

Other:

Yes	No	
☐	☐	Sexually Transmitted Disease (STD)
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Chronic fatigue
☐	☐	Fibromyalgia
☐	☐	Arthritis
☐	☐	Degenerative arthritis
☐	☐	Rheumatoid arthritis
☐	☐	Glaucoma
☐	☐	Thyroid disease
☐	☐	Hyperthyroid
☐	☐	Hypothyroid
☐	☐	Goiter
☐	☐	Thyroid cancer
☐	☐	HIV/AIDS
☐	☐	Diabetes
☐	☐	Steroid use
☐	☐	Skin cancer
☐	☐	Headaches
☐	☐	Weight Loss
☐	☐	Food Allergies

Please list any other medical problems:

_____

_____

_____

_____

Provider Signature:_____ Date:_____ Time: _____

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