Regional Health Partners

3915 Old Lee Hwy • Suite 21C • Fairfax VA 22030 Tel (703) 691-4000 • Fax (703) 691-4010

Patient Questionnaire

Name:_____ Date of Birth:_____ Date:_____
Reason for today's visit? ☐ Annual Exam ☐ Problem: _____(Please state.)
Who is your primary care provider? _____

Past Medical and Family History

1. What medications (prescription, OTC, herbal or vitamin supplements are you taking? _____
   _____
   Allergies to medications:_____
   Are you allergic to latex? ☐ Yes ☐ No
2. Have you ever been hospitalized? ☐ Yes ☐ No If yes, for what reason? _____
   Have you ever received a blood transfusion? ☐ Yes ☐ No

Past Surgical History

1. Have you ever had any surgery? ☐ Yes ☐ No If yes, please list the year and reason below:
   _____
   _____
2. Please list all biopsies: _____

Social History

1. Do you smoke? ☐ Yes ☐ No If you answered "No", please proceed to number 2.
   How many cigarettes do you smoke a day? (0) less than 15 (1) from 15 to 25 (2) more than 25
   What is the nicotine content of your cigarettes?
   (0) less than 0.8mg (1) from 0.8 to 1.5mg (2) more than 1.5mg
   Do you inhale? (0) Never (1) Sometimes (2) Always
   Do you smoke more frequently early in the day? (1) Yes (2) No
   When do you smoke your first cigarette?
   (0) more than half an hour after waking up (1) less than half an hour after waking up
   Which cigarette gives you the greatest pleasure? (1) first one in the day (0) another one
   Do you smoke even when you are so sick that you must stay in bed (with the flu or sore throat)?
   (1) Yes (0) No
   Is it hard for you not to smoke in no-smoking areas, such as theatres, airplanes, trains, restaurants or other public places? (1) Yes (0) No
   For results, add up the points associated with your answers.
   0-4: You are not dependent, or are just slightly dependent
   5-6: You are dependent.
   7-8: You are strongly dependent.
2. Do you drink alcohol? ☐ Yes ☐ No If you answered "No", please proceed to number 3.
   How often do you have a drink containing alcohol?
   (1)Monthly or less (2)2-4 times a month (3)2-3 times a week (4)4 or more times a week
   How many drinks containing alcohol do you have on a typical day when you are drinking?
   (0)1 or 2 (1)3 or 4 (2)5 or 6 (3)7, 8 or 9 (4)10 or more
   How often do you have six or more drinks on one occasion?
   (0)Never (1)Less than monthly (2)Monthly (3)Weekly (4)Daily or almost daily

How often during the last year have you found that you were not able to stop drinking once you had started? (0)Never (1)Less than monthly (2)Monthly (3)Weekly (4)Daily or almost daily

How often during the last year have you failed to do what was normally expected from you because of drinking? (0)Never (1)Less than monthly (2)Monthly (3)Weekly (4)Daily or almost daily

How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0)Never (1)Less than monthly (2)Monthly (3)Weekly (4)Daily or almost daily

How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?

(0)Never (1)Less than monthly (2)Monthly (3)Weekly (4)Daily or almost daily

How often during the last year have you had a feeling of guilt of remorse after drinking?

(0)Never (1)Less than monthly (2)Monthly (3)Weekly (4)Daily or almost daily

Have you or someone else been injured as a result of your drinking?

(0)No (2)Yes, but not in the last year (4)Yes, during the last year

Has a relative, friend, doctor or other healthcare professional expressed concern about your dinking or suggested you cut down? (0)No (2)Yes, but not in the last year (4)Yes, during the last year

For results, add up the points associated with your answers.

Scores 0-7: Congratulations. Please continue responsible drinking.
8-15: Please give some thought to the reduction of hazardous drinking.
16-19: WE ARE HERE TO HELP with counseling and close monitoring.
20+: You will need further diagnostic evaluation for alcohol dependence.

3. Do you use drugs? ☐ Yes ☐ No If so, please list: _____
4. Do you have problems with violence or abuse? Yes No
5. Do you work outside the home? ☐ Yes ☐ No If so, what type of work? _____
6. Marital Status: Single Married Divorced Separated Other
7. Are you sexually active? ☐ Yes ☐ No

Family/Genetic History

1. What is your race or ethnic background? _____
2. Does anyone in your family (parents/grandparents/aunts/uncles/siblings/children) have:

- ☐ Neural Tube Defect (spina bifida, anencephaly)
- ☐ Down Syndrome
- ☐ Thalassemia
- ☐ Tay-Sachs
- ☐ Cystic Fibrosis
- ☐ Hydrocephalus
- ☐ Deafness or Blindness
- ☐ Any Inherited Problem
- ☐ Cleft Lip or Palate
- ☐ Hypertension
- ☐ Thyroid Dysfunction
- ☐ Kidney Disease
- ☐ Psychiatric Disorder
- ☐ Cancer: Type _____ Family Member _____ Age of Diagnosis_____
  _____ _____ _____
- ☐ Congenital Heart Defect
- ☐ Sickle Cell Disease or Trait
- ☐ Hemophilia
- ☐ Muscular Dystrophy
- ☐ Mental Retardation
- ☐ Neurological Disorder (including seizures)
- ☐ Any Birth Defect (even if surgically corrected)
- ☐ Huntington's Chorea
- ☐ Diabetes
- ☐ Autoimmune Disease
- ☐ Asthma
- ☐ Heart Disease

Name:_____ Date of Birth:_____ Date:_____

Review of Systems Please check if any of the following symptoms apply to you:

General:
- Weight Loss
- Weight Gain
- Fever
- Fatigue

Height: _____
Weight:_____

Gastrointestinal:
- Bloody Stool
- Nausea/Vomiting/Indigestion
- Frequent Diarrhea
- Constipation
- Flatulence
- Pain

Eyes:
- Vision Change
- Double Vision
- Glasses Contacts

Ears/Nose/Throat:
- Hearing Problems
- Sore throat
- Headache
- Sinuses
- Mouth Sores
- Dental Problems

Genitourinary:
- Frequency
- Pain with Urination
- Painful Intercourse
- Blood in Urine
- Abnormal Periods
- Abnormal Vaginal Bleeding
- Abnormal Vaginal Discharge

Musculoskeletal:
- Muscle or Joint Pain
- Muscle Weakness

Skin:
- Dry Skin
- Rash
- Moles
- Ulcers

Breast:
- Discharge
- Pain
- Lumps

Neurologic:
- Trouble Walking
- Passing Out
- Severe Memory Loss
- Seizures
- Numbness

Psychiatric:
- Anxiety
- Depression
- Crying

Endocrine:
- Hot flashes
- Diabetes
- Hair loss
- Hypothyroidism
- Hyperthyroidism
- Heat/Cold Intolerance

Hematologic/Lymphatic:
- Bruises
- Bleeding
- Enlarged Lymph Nodes

Cardiovascular:
- Chest Pain
- Difficult Breathing
- Swelling of Legs
- Rapid Heart Beat

Respiratory:
- Shortness of Breath
- Chronic Cough
- Wheezing
- Coughing Up Blood

Allergic/Immunologic:
- Latex
- Other: _____

Other:_____

Form completed by ☐ Patient ☐ Office Staff ☐ Physician ☐ Other: _____	
Signature of Patient:	
Date reviewed by physician with patient: ___/___/__	Physician Signature:

Physician Notes:

Annual Review of History

Date reviewed: / /	Physician Signature:
Date reviewed: / /	Physician Signature:
Date reviewed: / /	Physician Signature: