Thomas Cigno, M.D.

Thomas V. Cigno M.D.
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203-244-7848 | www.CignoMD.com

Name:_____Date:_____

Adult Medical Questionnaire

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will help us formulate a treatment plan.

Today's Date: _____

Last Name:_____ First Name: _____ MI:_____

Date of Birth:_____

1. Have you recently had any major family changes: If yes, please explain:

2. Past Medical and Surgical History:

ILLNESSES	WHEN	COMMENTS
Anemia		
Arthritis		
Asthma		
Bronchitis		
Cancer		
Chronic Fatigue Syndrome		
Crohn's Disease or Ulcerative Colitis		
Diabetes		
Emphysema		
Epilepsy, Convulsions, or Seizures		
Gallstones		
Gout		
Heart Attack/Angina		

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Name:_____Date:_____

Heart Failure		
Hepatitis		
High Blood Fats (cholesterol, triglycerides)		
High Blood Pressure (hypertension)		
Irritable Bowel		
Kidney Stones		
Mononucleosis		
Pneumonia		
Rheumatic Fever		
Sinusitis		
Sleep Apnea		
Stroke		
Thyroid Disease		
Other (describe)		

INJURIES	WHEN	COMMENTS
Back Injury		
Broken Bone (describe)		
Head Injury		
Neck Injury		
Other (describe)		

DIAGNOSTIC STUDIES	WHEN	COMMENTS
Bone Density		
Pap Smear		
Mammogram		
Chest Xray		
Colonoscopy		
Cat Scan		
MRI		
Other (describe)		

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3. What medications are you taking now? Include non-prescription drugs:

MEDICATION NAME	DOSAGE

Are you allergic to any medications: ___Yes ___No
If yes, please list:

4. Please list all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate dosage in mg or IU and the form (e.g., calcium carbonate vs. calcium lactate) when possible:

VITAMIN/MINERAL/SUPPLEMENT NAME	DOSAGE

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Health History

Have you ever been hospitalized for illness? If so, please list when and why:

Have you ever had the following procedures? If so, please list the dates:

Coronary artery bypass surgery_____ Angioplasty or stent_____
Revascularization procedures_____

Surgical History

Please list all other operations with the dates when they occurred:

Social History

Tobacco use
Cigarettes _____Never _____Date you quit smoking _____Current smoker (number per day)

Other tobacco (Check all answers that apply): ____Pipe____Cigar ____Chewing tobacco
Number of years you've used this tobacco _____

Are you interested in quitting? ____Yes ____No Have you tried quitting in the past? _____
Are you exposed to second hand smoke? ____Yes ____No For how long? _____

Alcohol use
Do you drink alcohol? ____Yes ____No
If yes, how many drinks do you consume per week? _____ Alcohol type _____
Does your alcohol consumption have you or others concerned? ____Yes ____No

Other concerns

Caffeine intake
Coffee_____cups/day Tea_____cups/day Soda_____per day Diet or Regular? _____
Chocolate_____ounces per day Dark or Light? _____

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Health History

Weight

Are you satisfied with your weight? _____Yes _____No What is your goal weight? _____
When did you last weigh your goal weight? _____ How long were you at that weight? _____

Exercise

Do you exercise regularly? ____Yes ____No
What kind of exercise?

How long do you exercise in minutes? _____
How often?_____

If you do not exercise, why not?_____

Stress

How would you classify your stress level at work? ____Low ____Medium ____High
How would you classify your stress level at home? ____Low ____Medium ____High
Do you often feel anxious, angry, irritated or rushed? ____No ____Yes

How do you manage your stress?

Diet/Nutrition

How do you rate your diet? Please choose one: ____Good ____Fair ____Poor

How many daily servings of the following do you typically have?

____Whole grains ____Fruits ____Vegetables ____Legumes ____

How many times in one week do you consume the following items?

____Eggs ____Fish ____Chicken/Turkey ____Red meat ____Butter ____Margarine

____Other high fat dairy products ____Other low fat dairy products ____Fried foods ____High fat snacks

What type of cooking oil do you use? _____

Who prepares meals at home? _____

How often do you eat out? _____

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Health History

Please describe in detail a typical day of eating and drinking:

Breakfast:

Lunch:

Dinner:

Snacks (include time of day):

Beverages throughout the day:

Review of Symptoms
Please check any of the current problems you have on the list below:

CONSTITUTIONAL:	CHECK:
Fever/chills/sweats	
Unexplained weight loss/ gain	
Brittle nails	
Dry skin	
Change in skin texture	
Change in hair texture	
Inability to stand heat	
Inability to stand cold	
Change in energy/increased weakness	
Excessive thirst or urination	

RESPIRATORY:	
Cough/Wheeze	
Snoring	
Sleep apnea/CPAP	

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Name:_____Date:_____

EYES:	
Change in vision (Explain)	

EAR/NOSE/THROAT/MOUTH:	
Difficulty hearing/ringing in your ears	
Hay fever/allergies	
Problems with teeth/gums	

CARDIOVASCULAR:	
Chest pain/discomfort	
Palpitations (irregular heartbeats)	
Swelling in feet or legs	
Varicose veins	
Pain in extremities with exercise	

SKIN:	
Acanthosis nigricans (dark lines around neck or under arms)	
Skin tags	
Flattening of nail beds	

GENITOURINARY:	
Unusual frequency of urination	

SEXUAL:	
Problems with erectile function	

GASTROINTESTINAL:	
Abdominal pain	
Blood in bowel movement	
Heartburn	
Nausea/vomiting	
Diarrhea/constipation	
Bloating	

NEUROLOGICAL:	
Headaches	
Light-headedness	

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Memory loss	
Loss of coordination	
Tingling, pain or numbness in hands or feet	

PSYCHIATRIC:	
Problems with sleep	
Depression	
Panic attacks	
Mania	
Anxiety	
Anger issues	

BLOOD/LYMPHATIC:	
Easy bruising/bleeding	
Unexplained lumps	

JOINTS/MUSCLES:	
Pains or aches in muscles	
Pain or aches in joints	
Arthritis	
Muscle fatigue	
Stiffness or limitation of movement	
Back and/or neck pain	

Any other symptoms? If so, please list them:

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Health History

Family History

Please indicate the current status of your immediate family members. Include if each person is alive or deceased; the person's age now or at the time of death; if applicable, the cause of death; and any other relevant comments.

Mother's mother _____

Mother's father _____

Father's mother _____

Father's father _____

Mother _____

Father _____

Sister _____

Sister _____

Sister _____

Brother _____

Brother _____

Brother _____

Daughter _____

Daughter _____

Daughter _____

Son _____

Son _____

Son _____

Please use this space to list any additional family members:

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Please indicate with a check mark any family members who have had any of the following medical conditions:

Medical condition	**Mom**	**Dad**	**Sister**	**Brother**	**Daughter**	**Son**	**Mom's mom**	**Mom's dad**	**Dad's mom**	**Dad's dad**	**Mom's sister**	**Mom's brother**	**Dad's sister**	**Dad's brother**
Heart attack														
Stroke														
Diabetes-Type 2 (adult onset)														
Alcoholism														
Anemia														
Aortic Aneurysm														
Alzheimer's														
Arthritis														
Asthma														
Autoimmune disorder														
Bleeding problems														
Carotid artery disease														
Cancer														
Depression														
Diabetes-Type 1 (childhood onset)														
Other genetic disease														
High cholesterol (hyperlipidemia)														
High blood pressure (hypertension)														
Immunosuppressive disorders														
Kidney disease														
Osteoporosis														
Peripheral vascular disease														
Epilepsy (seizure disorder)														
Substance abuse														
Thyroid disorder														
Smoking														
Sleep apnea														

Thank you!