

### 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.

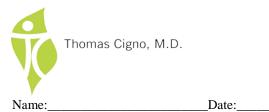
|            |             | Today's Date: |  |
|------------|-------------|---------------|--|
|            |             | •             |  |
| Last Name: | First Name: | MI:           |  |

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           |      |          |

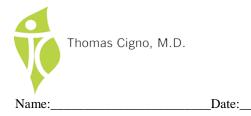


\_\_\_\_\_

| 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)   |      |          |



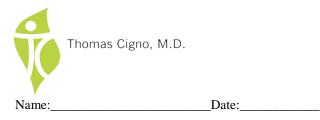
3. What medications are you taking now? Include non-prescription drugs:

| 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 |
|---------------------------------|--------|
|                                 |        |
|                                 |        |
|                                 |        |
|                                 |        |
|                                 |        |
|                                 |        |
|                                 |        |
|                                 |        |
|                                 |        |



## 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:

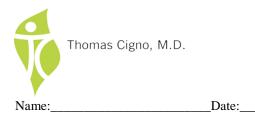
### **Social History**

| Tobacco use  |
|--|
| CigarettesNeverDate you quit smokingCurrent smoker (number per day)  |
| <i>Other tobacco</i> (Check all answers that apply):PipeCigarChewing tobacco<br>Number of years you've used this tobacco |
| Are you interested in quitting?YesNo Have you tried quitting in the past?  |
| Are you exposed to second hand smoke?YesNo For how long?   |
| Alcohol use  |
| Do you drink alcohol?YesNo   |
| f yes, how many drinks do you consume per week? Alcohol type   |
| Does your alcohol consumption have you or others concerned? <u>Yes</u> No  |
| Other concerns   |
| Caffeine intake  |
| Coffeecups/day Teacups/day Sodaper day Diet or Regular?  |
| Chocolateounces per day Dark or Light?   |

|       | Thomas Cigno, M.D. |       |  |
|-------|--------------------|-------|--|
| Name: |                    | Date: |  |

# Health History

| Weight         Are you satisfied with your weight?YesNo 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?YesNo What kind of exercise?   |  |  |
|   |  |  |
| How long do you exercise in minutes?<br>How often?  |  |  |
| If you do not exercise, why not?  |  |  |
| Stress How would you classify your stress level at work?LowMediumHigh How would you classify your stress level at home?LowMediumHigh Do you often feel anxious, angry, irritated or rushed?NoYes How do you manage your stress? |  |  |
|   |  |  |
|   |  |  |
| <i>Diet/Nutrition</i><br>How do you rate your diet? Please choose one:GoodFairPoor  |  |  |
| How many daily servings of the following do you typically have?   |  |  |
| Whole grainsFruitsVegetablesLegumes   |  |  |
| How many times in one week do you consume the following items?  |  |  |
| EggsFishChicken/TurkeyRed meatButterMargarine   |  |  |
| Other high fat dairy productsOther low fat dairy productsFried foodsHigh fat snacks   |  |  |
| What type of cooking oil do you use?  |  |  |
| Who prepares meals at home?   |  |  |
| How often do you eat out?   |  |  |



## 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:                     | <b>CHECK:</b> |
|-------------------------------------|---------------|
| 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       |               |

| <b>RESPIRATORY:</b> |  |
|---------------------|--|
| Cough/Wheeze        |  |
| Snoring             |  |
| Sleep apnea/CPAP    |  |



\_\_\_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 |  |



\_\_\_Date:\_\_\_\_\_

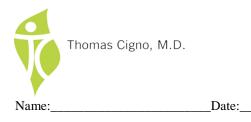
| Memory loss                                 |  |
|---|--|
| Loss of coordination                        |  |
| Tingling, pain or numbness in hands or feet |  |

| <b>PSYCHIATRIC:</b> |  |
|---------------------|--|
| Problems with sleep |  |
| Depression          |  |
| Panic attacks       |  |
| Mania               |  |
| Anxiety             |  |
| Anger issues        |  |

| <b>BLOOD/LYMPHATIC:</b> |  |
|-------------------------|--|
| 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:



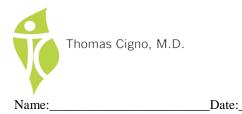
# Health History

### **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:



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

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