The Christ Hospital™ Health Network

**Primary Care**
**ESTABLISHED PATIENT QUESTIONNAIRE**

**Patient Name** ________________________ **Date of Birth** ________________

## Symptoms

Please check the box of any problem or concern related to the following symptoms that have been persistent or recurring since your last visit.

**Constitutional symptoms**
- ❑ Fever/Chills
- ❑ Fatigue
- ❑ Weight loss/gain (>5 lbs.)

**Eyes/Ears/Nose/Throat**
- ❑ Vision change
- ❑ Pain
- ❑ Hearing change
- ❑ Vertigo
- ❑ Sinus congestion/pressure
- ❑ Swelling or lumps in throat

**Cardiovascular**
- ❑ Chest pain
- ❑ Palpitations
- ❑ Edema/swelling in legs

**Respiratory**
- ❑ Shortness of breath
- ❑ Coughing

**Abdomen (GI/GU)**
- ❑ Abdominal pain
- ❑ Constipation
- ❑ Diarrhea
- ❑ Blood in stool/discolored stool
- ❑ Heartburn or indigestion
- ❑ Difficulty swallowing
- ❑ Nausea/vomiting
- ❑ Change in frequency of urination

**Musculoskeletal**
- ❑ Back pain/neck pain
- ❑ Joint pain or swelling
- ❑ Muscle pain

**Skin**
- ❑ Rash
- ❑ Skin growth
- ❑ New or changed moles
- ❑ Persistent itch

**Neurological**
- ❑ Headaches - frequent or severe
- ❑ Change in thinking, confusion
- ❑ Memory loss
- ❑ Trouble speaking
- ❑ Weakness
- ❑ Loss of coordination, falling
- ❑ Change in sensation-numbness

**Psychiatric**
- ❑ Change in mood or anxiety
- ❑ Trouble sleeping

**Endocrine**
- ❑ Excessive/increased thirst
- ❑ Heat/cold intolerance
- ❑ Too hot/cold

**Hematological/Lymphatic**
- ❑ Blood clotting problems
- ❑ Easy bruising or bleeding
- ❑ Enlarged lymph nodes

**Allergy/Immune System**
- ❑ Environmental allergies
- ❑ Drug allergies

## Medications

Please list both prescription and non-prescription medications you are currently taking:

| Medication | Dose | Times/day | Medication | Dose | Times/day |
|---|---|---|---|---|---|
| | | | | | |
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| | | | | | |

## Allergies

Do you have any drug or environmental allergies? ❑ No ❑ Yes If YES, please list below and describe reaction.

________________________ Reaction: ________________________
________________________ Reaction: ________________________
________________________ Reaction: ________________________
________________________ Reaction: ________________________

**Patient Name** ________________________________________ **Date of Birth** _______________________

**Surgeries**

- ❑ No Surgical History
- ❑ C-Section
- ❑ Breast biopsy
- ❑ Broken bones/fractures
- ❑ CABG/Heart Bypass
- ❑ Mastectomy
- ❑ Abdominal surgery
- ❑ Hernia repair
- ❑ Gall bladder removal
- ❑ Tonsillectomy
- ❑ Appendectomy
- ❑ Joint replacement
- ❑ Cosmetic surgery
- ❑ Colon removal
- ❑ Brain
- ❑ Hysterectomy
- ❑ Sterilization
- ❑ Other _____________

_____________________

_____________________

**Family Medical History** Please check each that apply and list the relationship of family member.

- ❑ Cancer ________________
- ❑ Asthma _______________
- ❑ Stroke ________________
- ❑ HIV/AIDS _____________
- ❑ Diabetes ______________

Arthritis _________________

- ❑ Seizures ___________________
- ❑ Migraines___________________
- ❑ Heart Problems _______________
- ❑ High Cholesterol _____________
- ❑ Skin Problems _______________
- ❑ Kidney Disease _______________
- ❑ High Blood Pressure _______________
- ❑ Thryoid Disease ___________________
- ❑ Clotting Disorder _________________
- ❑ Alcoholism ______________________

**Physician/Provider Signature:** ________________________________________ **Date:** ____________________