Stony Brook Medicine

Adult Outpatient History Questionnaire

Past Medical/Surgical History:

Please list any testing you have had within the last 6 months (bloodwork, MRI, MRA, Catscan, other) and date it was performed:

_____

Have you ever been hospitalized? □ Yes □ No Describe_____
Have you had any surgery? □ Yes □ No Describe_____
Have you had any Past Procedures? □ Yes □ No Describe_____

Family History:

Are you adopted? □ No □ Yes (if medical history of blood relatives known, describe below)
Father: □ Alive, Age: _____ □ Deceased, Cause of Death: _____
Mother: □ Alive, Age: _____ □ Deceased, Cause of Death: _____

Please list any illnesses in the following family members:
Father: _____ Mother: _____
Grandparents: _____ Sisters: _____
Brothers: _____ Children: _____
Other: _____

Have you ever been diagnosed in the past with any of the following?

	No	Yes	When did it start?	Was it resolved, if so when?
Arthritis				
Asthma				
Depression				
Diabetes				
Endocrine Disorder				
GI problems				
Heart disease				
High blood pressure				
High cholesterol				
Infectious disease				
Insomnia				
Kidney problems				
Lung problems				
Lyme Disease				
Memory Loss				
Migraine/Headache				
Psychiatric Illness				
Seizure				
Stroke/TIA				
Thyroid Disease				
Tuberculosis				
Urination at Night				
Other_____				

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Review of Systems:

Are you currently experiencing any of these symptoms?

Allergic/Immunological
- Seasonal allergies □ No □ Yes Describe _____
- Immune disorders □ No □ Yes Describe _____

Cardiovascular
- Chest pain, palpitations □ No □ Yes Describe _____
- Fainting □ No □ Yes Describe _____

Constitutional
- Fever, weight loss □ No □ Yes Describe _____

Ears/Nose/Mouth Throat □ No □ Yes Describe _____

Endocrine (thyroid) □ No □ Yes Describe _____

Eyes (glaucoma, cataracts) □ No □ Yes Describe _____

GI
- Blood in stool, nausea, vomit □ No □ Yes Describe _____

GU
- Pain with urination □ No □ Yes Describe _____
- Blood in urine □ No □ Yes Describe _____
- Sexual dysfunction □ No □ Yes Describe _____

Hematological/Lymphatic
- Bruising, lymph nodes □ No □ Yes Describe _____

Musculoskeletal
- Muscle aches, joint pain □ No □ Yes Describe _____

Neurologic
- Dizziness/spinning □ No □ Yes Describe _____
- Double vision □ No □ Yes Describe _____
- Headache □ No □ Yes Describe _____
- Hearing loss □ No □ Yes Describe _____
- Incoordination □ No □ Yes Describe _____
- Loss of vision □ No □ Yes Describe _____
- Memory loss □ No □ Yes Describe _____
- Numbness/tingling □ No □ Yes Describe _____
- Ringing in the ears □ No □ Yes Describe _____
- Sleep disturbances □ No □ Yes Describe _____
- Slurred speech □ No □ Yes Describe _____
- Weakness □ No □ Yes Describe _____

Psychiatric □ No □ Yes Describe _____

Respiratory
- Shortness of breath □ No □ Yes Describe _____
- Wheezing □ No □ Yes Describe _____

Skin/Breast
- Rash, lumps, bumps □ No □ Yes Describe _____