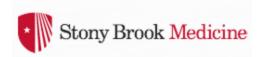


## **Adult Outpatient History Questionnaire**

Past Medica	al/Surgical I	History:			
Please list any t	esting you have	had within the last 6 month	ns (bloodw	ork, MRI,	MRA, Catscan, other) and date it was performed:
Have you ever b	been hospitalize	d?	□ Yes	□ No	Describe
Have you had any surgery?			□ Yes	□ No	Describe
Have you had any Past Procedures?			□ Yes		Describe
Family History:					
Are you adopte	d?	□ No	□ Yes	(if medi	cal history of blood relatives known, describe below)
Father	:	□ Alive, Age:			□ Deceased, Cause of Death:
Mothe	er:	□ Alive, Age:			□ Deceased, Cause of Death:
Please list any i	llnesses in the fo	ollowing family members:			
Father	:			Mother:	
				Sisters:	
Brothe	ers:			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				



Rash, lumps, bumps

## **Adult Outpatient History Questionnaire**

## **Review of Systems:** Are you currently experiencing any of these symptoms? Allergic/Immunological Seasonal allergies □ No □ Yes Describe \_\_\_\_\_ □ No □ Yes Describe \_\_\_\_\_ Immune disorders Cardiovascular □ No □ Yes Describe \_\_\_\_\_ Chest pain, palpitations Fainting □ No □ Yes Describe Constitutional □ No □ Yes Describe \_\_\_\_\_ Fever, weight loss Ears/Nose/Mouth Throat □ No □ Yes Describe □ No □ Yes Describe \_\_\_\_\_\_ Endocrine (thyroid) Eyes (glaucoma, cataracts) □ No □ Yes Describe GΙ □ No □ Yes Describe \_\_\_\_\_ Blood in stool, nausea, vomit GU □ No □ Yes Describe \_\_\_\_\_\_ Pain with urination Blood in urine □ No □ Yes Describe □ No □ Yes Describe \_\_\_\_\_\_ Sexual dysfunction Hematological/Lymphatic Bruising, lymph nodes □ No □ Yes Describe \_\_\_\_\_ Musculoskeletal Muscle aches, joint pain □ No □ Yes Describe Neurologic Dizziness/spinning □ No □ Yes Describe \_\_\_\_\_ □ No □ Yes Describe \_\_\_\_\_ Double vision □ No □ Yes Describe \_\_\_\_\_\_ Headache □ No □ Yes Describe \_\_\_\_\_ **Hearing loss** Incoordination □ No □ Yes Describe \_\_\_\_\_\_ Loss of vision □ No □ Yes Describe □ No □ Yes Describe \_\_\_\_\_ Memory loss Numbness/tingling □ No □ Yes Describe \_\_\_\_\_ Ringing in the ears □ No □ Yes Describe □ No □ Yes Describe \_\_\_\_\_\_ Sleep disturbances Describe \_\_\_\_\_ Slurred speech □ No □ Yes □ No □ Yes Describe \_\_\_\_\_ Weakness **Psychiatric** □ No □ Yes Describe Respiratory Shortness of breath □ No □ Yes Describe \_\_\_\_\_\_ □ No □ Yes Describe \_\_\_\_\_\_ Wheezing Skin/Breast

□ No □ Yes Describe \_\_\_\_\_