GARY POLK, M.D.

PATIENT QUESTIONNAIRE - PLEASE PRINT

Full name:____Date:____________________

Pharmacy/Location_______________________________Date of Birth:_____________Age:_________

CHIEF COMPLAINTS(List the problems about which you came to see the doctor)

1) ____

2)____

3)____

YOUR PAST MEDICAL HISTORY

Medical illness: Please check any of the following medical illnesses that you now have or have ever had, or list any others that are not listed below.

☐ Allergic Rhinitis	☐ COPD	☐ Hepatitis
☐ Arthritis	☐ Diabetes	☐ High Cholesterol
☐ Asthma	☐ Tuberculosis	☐ Pancreatitis
☐ Bronchitis	☐ Ulcers	☐ Pneumonia
☐ Cancer (type)____________________	☐ Emphysema	☐ Rheumatic Fever
☐ High Blood Pressure	☐ Epilepsy	☐ Urinary Tract Infection
☐ Colitis	☐ Heart attack	☐ Other

☐ Have you ever had a colonoscopy? ________YES ________NO If yes, when_________________________

☐ Sleep Apnea (*if yes, please answer next four questions*)

1) When & where was your sleep study performed?

____ _______________________________

Name of facility Date of study

2) Have you ever used or do you presently use a CPAP or Bi-Pap machine? ☐ Yes ☐ No

3) If yes, what are your pressure settings? ________________________________

4) Do you wear oxygen while you sleep? ☐ Yes ☐ No

YOUR PAST SURGICAL HISTORY

Appendectomy?	☐ Yes ☐ No
Gallbladder Removal?	☐ Yes ☐ No
Hemorrhoidectomy?	☐ Yes ☐ No
Hysterectomy?	☐ Yes ☐ No
Orthopedic Surgery? ☐ Yes ☐ NO If yes, what type:_______________________________	
Tonsillectomy?	☐ Yes ☐ No
Please list any other type of surgery you have had in the past:	

MEDICATIONS: Please list all medications, vitamins & supplements you take with dosage and frequency:

Medication	Dose (ie # of tablets)	Frequency

Are you allergic to:

Iodine ◻ Yes ◻ No Shellfish ◻ Yes ◻ No Latex ◻ Yes ◻ No

Silk Tape ◻ Yes ◻ No

LIST YOUR MEDICATION ALLERGIES

____

____

YOUR SOCIAL HISTORY

Current marital status? ◻ Single ◻ Married ◻ Separated ◻ Divorced ◻ Widowed ◻ Other

What type of occupation do you (or did) you have?

Are you still working? ◻ Yes ◻ No

Do you exercise? ◻ Yes ◻ No If yes, how often what type and what time of day?

____________________________ ____________________________

Type Type

____________________________ ____________________________

How often? Time of day?

YOUR SOCIAL HISTORY CONTINUED

Have you ever smoked cigarettes regularly? □ Yes □ No If yes, how many packs per day? (avg) _______

How many years?________ Still smoking? □ Yes □ No If no, when did you stop?____________________

Have you ever smoked cigars? □ Yes □ No If yes, how many per day? (avg) ______________

How many years?________ Still smoking? □ Yes □ No If no, when did you stop?____________________

Have you ever smoked a pipe? □ Yes □ No If yes, how many per day? (avg) ______________

How many years?________ Still smoking? □ Yes □ No If no, when did you stop?____________________

Have you ever dipped snuff? □ Yes □ No If yes, how much per day? (avg) ______________

How many years?________ Still dipping? □ Yes □ No If no, when did you stop?____________________

Have you ever chewed tobacco? □ Yes □ No If yes, how much per day? (avg) ______________

How many years?________ Still chewing? □ Yes □ No If no, when did you stop?____________________

Do you drink alcohol? □ Yes □ No If yes, how much per day? (avg) ______________

How many years?________ Still drinking? □ Yes □ No If no, when did you stop?____________________

Do you drink caffeine? □ Yes □ No

If yes, how much per day? (avg) ___________________________

YOUR FAMILY HISTORY

Father's History

Is your Father? □ Alive – Age _________________ □ Deceased – Age _______________

What types of health problems if any did he have?

Mother's History

Is your Mother? □ Alive – Age _________________ □ Deceased – Age _______________

What types of health problems if any did she have?

Do you have any brothers?

How many?____________ □ Alive – Ages _______________________ □ Deceased – Ages ______________

What types of health problems do/did they have?

Do you have any sisters?

How many?____________ □ Alive – Ages _______________________ □ Deceased – Ages ______________

What types of health problems do/did they have?

Do you have any sons?

How many?____________ □ Alive – Ages _______________________ □ Deceased – Ages ______________

What types of health problems do/did they have?

Do you have any daughters?

How many?____________ □ Alive – Ages _______________________ □ Deceased – Ages ______________

What types of health problems do/did they have?

REVIEW OF SYSTEMS

Please check any of the following symptoms or problems you are currently experiencing. If the problem has been resolved, leave it blank. If you are unsure, place a question mark (?) by the medical issue.

General	Skin	Head/Ear/Eyes/Nose/Throat
□ Weight loss	□ Recent change in hair distribution	□ Diplopia (double vision)
□ Weight gain	□ Changes in skin color	□ Glaucoma
□ Fatigue	□ Itching	□ Hearing loss
□ Fever	□ Rash	□ Nose bleeds
□ Night sweats	□ Hair loss	□ Sore throat
Do you eat a special diet? □Yes □No	□ Other____________________	□ Other____________________
Do you exercise regularly? □Yes □No		
Neck	**Respiratory**	**Breast/GYN**
□ Neck mass	□ Cough	□ Breast discharge
□ Neck pain	□ History of Tuberculosis	□ Breast swelling □ Breast mass
□ Neck stiffness	□ Shortness of breath	□ Breast tenderness
□ Swollen glands	□ Wheezing	□ Menses:Last one?__________
□ Other____________________	□ Other____________________	□ # Miscarriage(s) __________
		□ Other____________________
Cardiovascular	**Gastrointestinal**	**Genitourinary**
□ Chest pain	□ Abdominal pain	□ Blood in urine
□ Edema (swelling)__________	□ Nausea	□ Dysuria (pain with urination)
□ Fast/Irregular heartbeat	□ Vomiting	□ Frequency of urination
□ Orthopnea (trouble breathing while lying down)	□ Constipation/Diarrhea	□ Discharge
	□ Reflux	□ Nocturia (excessive urination at night)
□ Other____________________	□ Other____________________	□ History of malignancy (cancer)
		□ Other____________________
Musculoskeletal	**Neurological**	**Psychological**
□ Arthritis	□ Headaches	□ Anxiety
□ Back pain	□ Seizures	□ Depression
□ Joint pain	□ Strokes	□ Insomnia
□ Other____________________	□ Other____________________	□ Other____________________
Endocrine	**Hematological**	**Other**
□ Cold intolerance	□ Anemia	
□ Heat intolerance	□ Easy bleeding	
□ Thyroid problems	□ Easy bruising	
□ Other____________________	□ Other____________________	

Patient Signature ______________________________ **Physician Signature** ______________________________

Date ______________________________ **Date** ______________________________

We appreciate your cooperation in completing this form for your physician.