Etie Moghissi, MD, FACP, FACE **HEALTH QUESTIONNAIRE**

Date: _____ Referring Physician: _____

Patient: _____
(Last Name) **(First Name)** **(Middle Initial)**

Date of Birth: _____ Sex: **___M ___F**

What is the reason for your visit today? _____

_____

_____

_____

What other medical conditions are you currently being treated for_____

_____

_____

Please list any hospitalizations or surgeries you may have had in the past:_____

_____

_____

Please list all of your medications, including the amount and how often you are taking it: _____

_____

_____

Please list all of your food and drug allergies: _____

Do you smoke? _____ What? _____ How much? _____

Do you drink alcohol? _____ How often? _____ How much? _____

Do you exercise? _____ What kind? _____ How often? _____

Family history:
Do any of your family members have any of the following conditions?

Cancer? _____ Who? _____What kind? _____

Heart disease? _____ Who? _____

Diabetes? _____Who? _____

Any Endocrine conditions? _____Who? _____What? _____

Patient Signature:_____ Date:_____

Physician Signature:_____ Date:_____

Etie Moghissi, MD, FACP, FACE **REVIEW OF SYSTEMS**

Please CIRCLE if you have experienced any of the following over the past 6 months:

GENERAL

Weight loss?

Weight gain?

Fatigue?

Difficulty sleeping?

Feeling poorly in general?

Change in appetite?
Chronic pain?

VISION

Decrease/change in vision or blurriness? With or without pain?

Double vision?

HEAD AND NECK

Chronic head and neck problems?

Sores or non-healing ulcers in/around mouth?

Masses or growths?

Change in hearing acuity?

Dizziness?

Change in voice/hoarseness?

PULMONARY

Chronic pulmonary conditions?

Shortness of breath - @ rest or w/exertion?

Chest pain?

Cough?

Coughing up blood?

Wheezing?

CARDIOVASCULAR

Chronic cardiovascular disorders?

Chest pain (CP) or pressure?

Shortness of breath - @ rest or w/exertion?

Short of breath lying down)?

Lower extremity edema?

Sudden loss of consciousness (syncope)?

Sense of rapid or irregular heart beat, palpitations?

Calf/leg pain/cramps w/ambulation?

Wounds/ulcers in feet?
Difficult/slow to heal?

GASTROINTESTINAL

Chronic GI disorders?

Heart burn?

Abdominal pain?

Difficulty swallowing?

Pain upon swallowing?

Nausea or vomiting?

Abdominal swelling or distention?

Jaundice (yellowish coloration of skin)?

Vomiting blood?

Black stools?

Bloody stools?

Constipation?

Diarrhea or other change in bowel habits?

GENITO-URINARY

Incontinence (unintentional loss of urine)?

Blood in urine?

Burning with urination?

Frequent urination at night?

Diminished sex drive?

Erectile dysfunction

Incomplete emptying?

Hesitancy urinating?

Decreased force of stream?

Need to void soon after urinating?

HEMATOLOGY/ONCOLOGY

Fevers, chills, sweats, weight loss?

Abnormal bleeding/brusing?

New/growing lumps or bumps?

Hypercoaguability?

OB/GYN/BREAST

Chronic or past disease?

Irregular Menses?

Sweats?

Past pregnancies?

Vaginal discharge?

Sexual problems

Breast mass, pain or discharge?

Therapeutic or spontaneous abortions?

Hx STIs?

NEUROLOGICAL

Known disease?

Sudden loss of neurological function?

Abrupt loss/change in level of consciousness?

Witnessed seizure activity?

Numbness?

Weakness?

Dizziness?

Balance problems?

Headache?

Tremor?

ENDOCRINE

Known endocrine/hormonal condition?

Fatigue?

Weight loss?

Weight gain?

Excessive thirst?

Frequent urination?

INFECTIOUS DISEASES

Known disease?

Fevers, chills, or sweats?

MUSCULOSKELETAL

Known disease?

Joint pain?

Muscle ache?

Joint swelling?

Joint redness?

Lower back pain?

MENTAL HEALTH

Known mental health disorder?

Do you feel sad or depressed much of the time?

Alcohol, other substance abuse?

Anxious much of the time?

Memory problems?

Confusion?

SKIN AND HAIR

Hair Loss

Known disease?

Skin eruptions/rashes?

Growths?

Sores that grow and/or don't heal?

Lesions changing in size, shape, or color?

Itching?

Patient Signature: _____

Date: _____

Physician Signature:_____

THANK YOU!