USE PATIENT PLATE

UNIVERSITY OF CALIFORNIA DAVIS
MEDICAL CENTER,
SACRAMENTO, CALIFORNIA

PATIENT QUESTIONNAIRE

VISIT INFORMATION	FOR CLINIC USE ONLY
Name of Pharmacy: ______	BP: ______ Pulse: ______ Temp: ______
Address: ______	HT: ______ Weight: ______ Resp: ______
City: ______	Signature: ______

PREVIOUS MEDICAL HISTORY:

Medication Allergies & Reactions ______

Other Allergies & Reactions ______

Current Medical Problems (i.e. Diabetes, Heart Disease, etc): ______

Medications:

Name	Dosage	Name	Dosage

Do you take aspirin/Ibuprofen/Motrin? Yes No

List all previous surgery/hospitalizations

Procedure:	**Date**

SOCIAL HISTORY

- Do you currently smoke? **Yes** **No**
  If yes, number of packs per day? ______
  Number of years? ______
  If no, have you smoked in the past? Yes No
  If yes, date you quit: ____/____/____
- Do you drink alcohol? **Yes** **No**
  Type - *beer / *wine / *mixed drinks / other:
  How much per day: ______
  If no, did you drink in the past? Yes No
  If yes, date you quit: ____/____/____

Do you use recreational drugs? **Yes** **No**
If yes what? ______
If no, have you used them in the past? Yes No
If yes, what? ______

Do you work outside the home? **Yes** **No**
Occupation: ______

Are you retired? **Yes** **No**
Previous Occupation: ______

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FAMILY HISTORY

Are there diseases that run in your family? (i.e., Cancer, Diabetes, Heart disease, Bleeding disorders)

Relationship (Family member)	Disease

PLEASE CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD

RESPIRATORY	Yes	No	Do Not Know
Daily chronic cough	❑	❑	❑
Sputum, phlegm or mucus production	❑	❑	❑
Asthma, wheezing	❑	❑	❑
Bronchitis, Emphysema, COPD	❑	❑	❑
Tuberculosis (TB)	❑	❑	❑
Can you walk up 2 flights of stairs without stopping to take a breath?	❑	❑	❑
CARDIOVASCULAR			
Chest pain, angina, heart attack	❑	❑	❑
Leg swelling, CHF (congestive heart failure)	❑	❑	❑
Shortness of breath	❑	❑	❑
Sleep on more than 2 pillows or wake up a night short of breath?	❑	❑	❑
High blood pressure, hypertension	❑	❑	❑
Heart murmur, rheumatic fever	❑	❑	❑
Cramping in legs when walking	❑	❑	❑
Phlebitis (blood clots)	❑	❑	❑
ENDOCRINE			
Diabetes, high or low blood sugar	❑	❑	❑
Thyroid problems, heat or cold intolerance	❑	❑	❑
HEMATOLOGIC			
Bleeding problems	❑	❑	❑
Anemia	❑	❑	❑

DERMATOLOGIC	Yes	No	Do Not Know
Skin Cancer	❑	❑	❑
GASTROINTESTINAL			
Hiatal hernia, heartburn	❑	❑	❑
Ulcers, vomiting blood	❑	❑	❑
Hepatitis, jaundice	❑	❑	❑
Liver disease, cirrhosis	❑	❑	❑
GENITOURINARY			
Could you be pregnant?	❑	❑	❑
Difficulty passing urine	❑	❑	❑
At risk for AIDS or venereal disease (VD)	❑	❑	❑
Kidney Disease	❑	❑	❑
MUSCULOSKELETAL			
Physical limitations or prosthesis (artificial leg, eye)	❑	❑	❑
Arthritis (jaw, neck, back)	❑	❑	❑
NEUROLOGICAL/ PSYCHIATRIC			
Depression	❑	❑	❑
Seizures, convulsions, fainting, epilepsy	❑	❑	❑
Stroke, fleeting blindness or weakness	❑	❑	❑
Paralysis	❑	❑	❑
Psychiatric treatment	❑	❑	❑
GENERAL			
Headaches, unexplained weight loss, fatigue	❑		❑❑

Other ______________________________

Patient/Representative Signature: ______________________________ Date: ______________

Patient Signature: ______________________________ Date: ______________

Physician Signature: ______________________ PI # ____________ Date: ______________