Atlantic
Medical Group
ATLANTIC HEALTH SYSTEM

MEDICAL QUESTIONNAIRE

PATIENT ID HERE

PATIENT INFORMATION:			
Last Name:	First Name:	Date of Birth:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:		
E-Mail Address:			
Employer:	Occupation:	Work Phone:	
Primary Language:	Ethnic Origin:	Race:	
EMERGENCY CONTACT INFORMATION:			
Name:	Relationship:	Phone:	
PRIMARY INSURANCE:			
POLICY HOLDER			
Last Name:	First Name:	Date of Birth:	
Address:	City:	State:	Zip:
Relationship to Patient:	Social Security Number:		
Employer:	Employer Phone Number:		
Address:	City:	State:	Zip:
Insurance Name:			
Address:	City:	State:	Zip:
Insurance ID#:	Group #:		
SECONDARY INSURANCE:			
POLICY HOLDER			
Last Name:	First Name:	Date of Birth:	
Address:	City:	State:	Zip:
Relationship to Patient:	Social Security Number:		
Employer:	Employer Phone Number:		
Address:	City:	State:	Zip:
Insurance Name:			
Address:	City:	State:	Zip:
Insurance ID#:	Group #:		

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Can we leave a message on home/cell phone with test results? HOME: ☐ YES ☐ NO CELL: ☐ YES ☐ NO

Can we speak to a family member about your care and test results? ☐ YES ☐ NO

If yes, please list name(s): _____

Pharmacy: _____ Location: _____ Phone: _____

Do you have a living will / advance directive? ☐ YES ☐ NO

If yes, please provide us a copy to file in your medical chart.

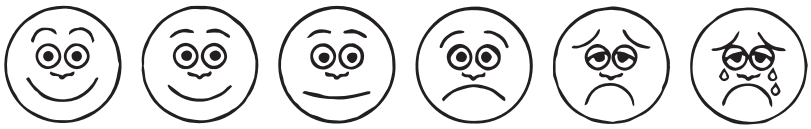
If no, would you like to be provided with this information? ☐ YES ☐ NO

REASON FOR VISIT:

Please list your present health concerns, problems or symptoms: _____

_____

_____



Are you having pain? ☐ YES ☐ NO

If yes, what level? _____

Where? _____

ALLERGIES or intolerance to medications (include type of reaction): _____

_____

_____ ☐ **NONE**

NAME OF MEDICATION INCLUDE -VITAMINS-HERBS & OVER THE COUNTER ☐ **CHECK BOX IF YOU TAKE NO MEDICATIONS**	**DOSAGE** mg/units puffs/drops	**FREQUENCY** How many times a day? Morning and/or night? After meals?	DO YOU NEED REFILLS?

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VACCINATIONS:

Check if you have had the following and include the date (if known):

☐ Tetanus _____ ☐ Flu _____ ☐ Pneumonia _____

☐ Hepatitis A _____ ☐ Hepatitis B _____ ☐ Shingles _____

☐ Positive PPD or Mantoux (Tuberculosis Skin Test) _____

PAST MEDICAL HISTORY: PLEASE CHECK WHETHER YOU HAVE EVER HAD THE FOLLOWING:					
	YES	NO		YES	NO
HIGH BLOOD PRESSURE			PANCREATITIS		
DIABETES: TYPE 1 TYPE 2			KIDNEY PROBLEMS		
CANCER: _____			HIGH PSA (MEN ONLY)		
HEART MURMUR			SEIZURE		
HEART PROBLEMS			DEPRESSION OR ANXIETY		
ASTHMA			STROKE		
EMPHYSEMA OR COPD			ANEMIA/BLOOD DISEASE		
POSITIVE SKIN TEST FOR TB			THYROID PROBLEMS		
TUBERCULOSIS			ARTHRITIS		
BLOOD CLOTS			HIGH CHOLESTEROL		
ULCERS			HIV, AIDS, STDs		
COLON POLYPS			MIGRAINE HEADACHES		
GALL BLADDER PROBLEMS			GOUT		
HEPATITIS OR JAUNDICE			LIVER PROBLEMS		
SLEEP APNEA			ALCOHOLISM		
HEPATITIS C			IRRITABLE BOWEL (IBS)		
CROHN'S DISEASE			OSTEOPOROSIS		
OTHER:			**OTHER:**		

Have you ever been hospitalized? ☐ YES ☐ NO

If yes, please explain below:

Year	Reason for Hospitalization
_____	_____
_____	_____
_____	_____

Have you ever had surgery? ☐ YES ☐ NO

If yes, please explain below:

Year	Type of Surgery
_____	_____
_____	_____
_____	_____

Have you had any falls in the past year? ☐ YES ☐ NO If so, did the fall result in injury? _____

_____

Over the past 2 weeks, have you felt down, depressed, or hopeless? ☐ YES ☐ NO

Do you have little interest or pleasure doing things? ☐ YES ☐ NO

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PREVENTIVE CARE: List dates of the most recent preventive services you have received below

Test	Date of Last Test	Never Performed
Colonoscopy	_____	☐
Cholesterol Test	_____	☐
HIV Test	_____	☐
Hearing Test	_____	☐
Vision Test	_____	☐
PSA/Prostate Exam	_____	☐

FAMILY HISTORY:	AGE IF LIVING	AGE AT DEATH	HEALTH PROBLEMS OR CAUSE OF DEATH
MOTHER:			
FATHER:			
BROTHERS:			
SISTERS:			
CHILDREN:			

SOCIAL HISTORY:

Tobacco: Do you currently smoke? ☐ YES ☐ NO

If yes, how many per day / week? _____

If no, have you smoked in the past? ☐ YES ☐ NO

Alcohol: Do you drink alcohol, beer or wine? ☐ YES ☐ NO

If yes, how much per week / month? _____

If no, have you in the past? ☐ YES ☐ NO

Do you consume caffeine? ☐ YES ☐ NO If yes, how many cups per day? _____

Do you use recreational drugs? ☐ YES ☐ NO

Do you exercise daily / weekly? ☐ YES ☐ NO If yes, what kind? _____

How would you rate your diet? ☐ GOOD ☐ FAIR ☐ POOR

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Type of diet: ☐ Balanced ☐ Vegetarian ☐ Diabetic ☐ Low Salt

☐ Low Fat ☐ Low Carb ☐ Other: _____

Would you like advice on your diet? ☐ YES ☐ NO

Are you sexually active? ☐ YES ☐ NO Contraceptive method: _____

Have you been a victim of ☐ Physical Abuse ☐ Sexual Abuse

Comments: _____

Are you afraid of your partner? ☐ YES ☐ NO

WOMEN'S HEALTH HISTORY:

Total number of pregnancies: _____ Number of births: _____

Date of last menstrual period, if you are still menstruating: _____

Age of your first period (menstruation): _____

Age that your periods ceased (menopause): _____

Date of last mammogram: _____ Abnormal? ☐ YES ☐ NO

Date of last pap smear: _____ Abnormal? ☐ YES ☐ NO

Date of last bone density: _____ Abnormal? ☐ YES ☐ NO

Have you ever used birth control pills? ☐ YES ☐ NO If yes, how long? _____

Have you ever taken hormone replacement therapy? ☐ YES ☐ NO If yes, how long? _____

Have you ever been given fertility drugs? ☐ YES ☐ NO If yes, how long? _____

Have you ever used Tamoxifen or Raloxifen, or similar medication? ☐ YES ☐ NO If yes, how long? _____

Are your ancestors of Ashkenazi descent? ☐ YES ☐ NO

REVIEW OF SYSTEMS: Please indicate any personal history below

CONSTITUTION:	**NO**	**YES**
Activity change	☐	☐
Appetitie change	☐	☐
Chills	☐	☐
Increase sweating	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Unexpected weight	☐	☐
RESPIRATORY:		
Apnea	☐	☐
Chest tightness	☐	☐
Choking	☐	☐
Cough	☐	☐
Shortness of breath	☐	☐
Stridor	☐	☐
Wheezing	☐	☐

CARDIOVASCULAR:	**NO**	**YES**
Chest pain	☐	☐
Leg swelling	☐	☐
Palpitations	☐	☐
PSYCHIATRIC:		
Agitation	☐	☐
Behavior problem	☐	☐
Confusion	☐	☐
Decreased concentration	☐	☐
Uneasy mood	☐	☐
Hallucinations	☐	☐
Hyperactive	☐	☐
Nervous/anxious	☐	☐
Self-injury	☐	☐
Sleep disturbance	☐	☐
Suicidal	☐	☐

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REVIEW OF SYSTEMS (continued): Please indicate any personal history below

NEUROLOGICAL:	NO	YES
Dizziness	☐	☐
Facial asymmetry	☐	☐
Headaches	☐	☐
Light-headedness	☐	☐
Numbness	☐	☐
Seizures	☐	☐
Speech difficulty	☐	☐
Fainting	☐	☐
Tremors	☐	☐
Weakness	☐	☐

GENITOURINARY:		
Difficulty urinating	☐	☐
Painful urination	☐	☐
Bladder control issues	☐	☐
Stomach pain	☐	☐
Frequency	☐	☐
Genital sore	☐	☐
Blood in urine	☐	☐
Penile discharge	☐	☐
Penile pain	☐	☐
Penile swelling	☐	☐
Scrotal swelling	☐	☐
Testicular pain	☐	☐
Urgency	☐	☐
Urine decreased	☐	☐

GASTROINTESTINAL:		
Abdominal distention	☐	☐
Abdonimal pain	☐	☐
Anal bleeding	☐	☐
Blood in stool	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Nausea	☐	☐
Rectal pain	☐	☐
Vomiting	☐	☐

EYES:		
Eye discharge	☐	☐
Eye itching	☐	☐
Eye pain	☐	☐
Eye redness	☐	☐
Light sensitivity	☐	☐
Visual disturbances	☐	☐

SKIN:	NO	YES
Color change	☐	☐
Pallor	☐	☐
Rash	☐	☐
Wound	☐	☐

HEAD/EARS/NOSE/THROAT:		
Congestion	☐	☐
Dental problem	☐	☐
Drooling	☐	☐
Ear discharge	☐	☐
Ear pain	☐	☐
Facial swelling	☐	☐
Hearing loss	☐	☐
Mouth sores	☐	☐
Nosebleeds	☐	☐
Postnasal drip	☐	☐
Rhinorrhea	☐	☐
Sinus pressure	☐	☐
Sneezing	☐	☐
Sore throat	☐	☐
Tinnitus	☐	☐
Trouble swallowing	☐	☐

HEMOTOLOGIC and LYMPHATIC:		
Swollen lymph nodes	☐	☐
Bruises/bleeds easily	☐	☐

ENDOCRINE:		
Cold or heat intolerance	☐	☐
Increased thirst	☐	☐
Increased urine	☐	☐
Increased hunger	☐	☐

MUSCLE:		
Arthritis	☐	☐
Back pain	☐	☐
Gait problem	☐	☐
Joint swelling or pain	☐	☐
Muscle pain	☐	☐
Neck pain/stiffness	☐	☐

ALLERGIC/IMMUNO:		
Env. allergies	☐	☐
Food allergies	☐	☐
Immunocompromised	☐	☐