Hendricks Regional Health
Bainbridge

Pre-Examination Adult Patient Questionnaire

Mr.
Mrs.
Miss
Full Name_____ Birth Date:_____ Age:_____
Occupation:_____

Name and address of previous family doctor: _____

Current Medicines:
(list both regular and occasional medicine)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES:
(check those which you have or have had)

☐Hives or generalized swelling
☐Drugs, injections or dental anesthetics
☐Eczema

SURGERIES:
(List all operations & dates)

1. _____
2. _____
3. _____
4. _____

HOSPITALIZATIONS:
(List all hospitalizations and dates not listed above)

1. _____
2. _____
3. _____
4. _____

Adult Illnesses
(check those you have had)

☐Migraine Headaches
☐Epilepsy
☐Mental Illness or nervous breakdown
☐Polio or Meningitis
☐Stroke or Paralysis
☐Other diseases of brain or nervous system
☐Impairment of sight, hearing or speech
☐Heart attack or Angina Pectoris
☐High or Low Blood Pressure
☐Heart Murmur
☐Rheumatic Heart Disease
☐Varicose Veins or Blood Clots
☐Other heart or circulatory disease
☐Tuberculosis
☐COPD/Emphysema
☐Asthma
☐Hay Fever
☐Other disease of the lungs
☐Duodenal or stomach ulcer, nervous stomach
☐Liver or gall bladder disease
☐Colitis or spastic colon
☐ Diverticulitis
☐ Jaundice
☐ Hernia
☐ Hemorrhoids
☐Other disease of stomach, intestines, rectum
☐Brights' Disease, Nephritis or Kidney infection
☐Kidney Stone
☐Bladder or Prostate trouble
☐Venereal disease
☐Infection of the testicles
☐Any other kidney or urinary disease
☐Arthritis, Rheumatism or Gout

Adult Illnesses (continued)
(check those you have had)

☐Back strain or sciatica or disorder of back or spine
☐Any other disorder of or injury to bones or joints
☐Neuritis or neuralgia
☐Diabetes
☐Thyroid disorder or Goiter
☐Any other disease /gland enlargement
☐Cancer, Tumor or Cyst
☐Frequent boils or skin infections
☐Dermatitis, Psoriasis or Eczema
☐Anemia
☐Any other blood disorder

DIAGNOSTIC PROCEDURES & TREATMENTS
(give dates of those you have had: check if ABNORMAL)

☐Blood Transfusion (donated)_____ ☐Other
☐Blood Transfusion (received)_____
☐Other special X-rays_____
☐Other diagnostic procedures or test _____
☐Electrocardiogram_____
☐Last Eye Exam_____

IMMUNIZATIONS/Disease History:
(give dates of most recent)

Small Pox_____
Tetanus_____
Polio_____
Flu or Cold Shot_____
Chicken Pox _____
Other:_____

SOCIAL HISTORY:

Tobacco _____
Coffee _____
Alcohol _____
Exercise _____

Patient Name _____

(patient questionnaire continued)

FAMILY HISTORY (List any health problems)

Father _____
Mother _____
Brothers/Sisters _____
_____
_____
Wife or Husband _____
Children _____
_____
_____
_____

CHECK THOSE ILLNESSES SUFFERED BY BLOOD RELATIVES:

Relationship

☐Cancer _____
☐Tuberculosis _____
☐Diabetes _____
☐High Blood Pressure _____
☐Epilepsy _____
☐Thyroid Disease _____
☐Kidney diseases _____
☐Blood disorders _____
☐Allergies _____
☐Insanity or Suicide _____
☐Heart or circulation _____

Does any other illness run in your family?
List:_____
_____

FOR WOMEN ONLY

Gynecology History
Age menstrual period began_____
Date of last menstrual period_____
Length of menstrual cycle (from beginning to
Duration of menstrual period_____days

CHECK IF YOU HAVE THE FOLLOWING:

☐Menstrual irregularity
☐Menstrual cramps
☐Swelling before or during periods
☐Mental tension before or during periods
☐Decreased menstrual flow or ☐Flooding
☐Hormone Replacement
☐Vaginal bleeding/spotting between periods
☐Vaginal discharge or infection
☐Hot flashes

Date of last pelvic exam and Pap Smear
_____

OB HISTORY

Number of pregnancies_____
Number of live births _____
Birth years _____
Number of miscarriages _____
Years _____
Any complications of pregnancy
or deliveries? _____
Are you pregnant now? _____

Patient Name _____

Cardiology

Chest pain	yes	no
Leg swelling	yes	no
Varicose Veins	yes	no
Palpitations	yes	no

Constitutional

Fatigue	yes	no
Fever	yes	no
Weight changes	yes	no

Dermatology

Change is skin/hair/nails	yes	no
Breast lump	yes	no
Rash	yes	no
Itching	yes	no

Endocrinology

Thyroid issues	yes	no
Gland or hormone issues	yes	no
Diabetes	yes	no
Heat intolerance	yes	no
Cold intolerance	yes	no
Skin changes	yes	no

Ear/Nose/Throat

Sores in mouth	yes	no
Ear pain	yes	no
Sinus problems	yes	no
Hearing loss	yes	no
Ringing in ears	yes	no
Nose bleeds	yes	no
Sore throat	yes	no
Swollen glands in neck	yes	no

Female Reproductive

Last pap date ____ normal	yes	no
Last mammogram ___ normal	yes	no
Abnormal vaginal discharge	yes	no
Irregular menses	yes	no
Painful menstruation	yes	no
Breast pain	yes	no
no		
Nipple discharge	yes	no

Gastroenterology

Nausea	yes	no
Diarrhea	yes	no
Abdominal pain	yes	no
Painful bowel movements	yes	no
Vomiting	yes	no
Change in bowel habits	yes	no
Headaches	yes	no
Constipation	yes	no
Blood in Stool	yes	no

Hematology/Lymphatic

Unusual bleeding or bruising	yes	no
Phlebitis	yes	no
Slow to heal after cuts	yes	no
Anemia	yes	no
Blood transfusion	yes	no

Male Reproductive

Testicle pain	yes	no
Sexual difficulties	yes	no

Musculoskeletal

Muscle weakness	yes	no
Muscle pain or cramps	yes	no
Difficulty walking	yes	no
Joint pain	yes	no
Joint swelling	yes	no
Joint stiffness	yes	no

Neurology

History of head trauma	yes	no
History of stroke	yes	no
Seizures	yes	no
Tremor	yes	no
Tingling/numbness	yes	no
Dizziness	yes	no
Memory loss	yes	no

Psychology

Nervousness	yes	no
Depression	yes	no

Respiratory

Short of breath with exercise	yes	no
Short of breath lying down	yes	no
Wheezing	yes	no
Persistent Cough	yes	no
Coughing up blood	yes	no

Urology

Change in force of strain when urinating	yes	
Urinary Frequency	yes	no
Pain with urination	yes	no
Urinary incontinence	yes	no
Blood in urine	yes	no
Kidney Stones	yes	no