unitedregional physician group

Patient Questionnaire

CONSTITUTIONAL

Change in appetite	_____ Yes	_____ No
Fatigue	_____ Yes	_____ No
Fever	_____ Yes	_____ No
Weakness	_____ Yes	_____ No

CARDIOVASCULAR

Chest Pain	_____ Yes	_____ No
Sudden heart beat change	_____ Yes	_____ No
Shortness of Breath	_____ Yes	_____ No

ENDOCRINE

Heat intolerance	_____ Yes	_____ No
Cold intolerance	_____ Yes	_____ No

GASTROINTESTINAL

Change in bowel habit	_____ Yes	_____ No
Nausea	_____ Yes	_____ No
Vomiting	_____ Yes	_____ No
Diarrhea	_____ Yes	_____ No
Constipation	_____ Yes	_____ No
Blood in stool	_____ Yes	_____ No
Stomach pain	_____ Yes	_____ No

New Patients

Please complete both the top and bottom sections

EYES/ENT

Wear glasses/contact lenses	_____ Yes	_____ No
Blurred or double vision	_____ Yes	_____ No
Hearing loss	_____ Yes	_____ No
Ringing in ears	_____ Yes	_____ No
Nasal congestion	_____ Yes	_____ No

RESPIRATORY

Frequent coughing	_____ Yes	_____ No
Spitting up blood	_____ Yes	_____ No
Asthma or wheezing	_____ Yes	_____ No

GENITOURINARY

Burning or painful urination	_____ Yes	_____ No
Frequent urination	_____ Yes	_____ No
Blood in urine	_____ Yes	_____ No
Incontinence or dribbling	_____ Yes	_____ No

HEMATOLOGIC/LYMPHATIC

Easily bleeding	_____ Yes	_____ No
Easily bruising	_____ Yes	_____ No
Blood clot	_____ Yes	_____ No

NEUROLOGICAL

Dizziness	_____ Yes	_____ No
Difficulty walking	_____ Yes	_____ No
Frequent headaches	_____ Yes	_____ No
Light-headed	_____ Yes	_____ No
Numbness or tingling	_____ Yes	_____ No
Convulsions	_____ Yes	_____ No
Tremors	_____ Yes	_____ No

SKIN

Change in skin color	_____ Yes	_____ No
Change in nails	_____ Yes	_____ No
Itching	_____ Yes	_____ No
Rash	_____ Yes	_____ No

MUSCULOSKELETAL

Back pain
Joint pain
Muscle weakness
Joint stiffness

Patient signature _____ Date _____

Patient date of birth _____