



Stormy Valdespino, FNP-C

PATIENT INFORMATION

In order to provide the best medical care possible, I must know not only what your present symptoms are, but also what diseases you have been exposed to and what problems you may be at risk for developing. For this reason you are requested to carefully fill out this screening health questionnaire. This along with the history and examination I will obtain when you visit with me will provide a complete medical evaluation of your current and potential medical problems.

DATE:

Patient's Name (Last, First):		Sex: <input type="checkbox"/> F <input type="checkbox"/> M	DOB:	Age:
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		SSN:		
Mailing Address: (Street, City, State, Zip):				
Home Address: (Street, City, State, Zip):				
Home Phone ()	Work Phone ()	Cell Phone ()		
Home Fax ()	Work Fax ()	Email Address:		
What is your primary means of contact? <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email <input type="checkbox"/> Fax (Home or Work)				
Insurance Company:		Policy No:	Group No:	
Primary Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	Primary Insured Name	SSN	DOB	

PLEASE COMPLETE THE FOLLOWING QUESTIONS:

Please state why you are coming to see the doctor:

What are your expectations of this visit?

INJURIES ~ Please list serious injuries and broken bones with approximate dates:

OPERATIONS ~ Please list the operations you have had, do not omit minor operations such as tonsils, vasectomy, D&C, etc.:

Operation:	Date:	Hospital:	Surgeon:

HOSPITALIZATIONS ~ Please list your hospitalizations other than those described above:

Illness:	Date:	Hospital:	Physician:

MEDICATIONS ~ Please list all current medications including vitamins and supplements:

Medication:	Strength:	Dosage:	Medication:	Strength:	Dosage:

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE BEEN TROUBLED WITH:

GENERAL:	<input type="checkbox"/> Weight loss (how much _____) <input type="checkbox"/> Weight gain (how much _____) <input type="checkbox"/> Over what period of time? _____		
	<input type="checkbox"/> Poor appetite <input type="checkbox"/> Weakness <input type="checkbox"/> Night sweats		
SKIN:	Dermatologist:	Phone no:	Date of last exam:
	<input type="checkbox"/> Burning <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Acne <input type="checkbox"/> Psoriasis <input type="checkbox"/> Melanoma <input type="checkbox"/> Change in mole		
HEAD:	<input type="checkbox"/> Headache (more than one per week) <input type="checkbox"/> Dizziness/lightheadedness <input type="checkbox"/> History of migraines		
EYES:	<input type="checkbox"/> Double vision <input type="checkbox"/> Blurred vision <input type="checkbox"/> Redness <input type="checkbox"/> Tearing		
	Ophthalmologist:	Phone no:	Date of last exam:
EARS:	<input type="checkbox"/> Earache <input type="checkbox"/> Drainage or discharge from ear <input type="checkbox"/> Vertigo <input type="checkbox"/> Tingling or other noises		
	<input type="checkbox"/> Difficulty hearing (how long? _____)		
NOSE:	Do you frequently have a stuffy nose when you do not have a cold? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Frequent nose bleeds <input type="checkbox"/> Post nasal drip <input type="checkbox"/> Trouble smelling <input type="checkbox"/> Allergies (If yes, to what?)		
MOUTH:	<input type="checkbox"/> Dentures <input type="checkbox"/> Dry mouth <input type="checkbox"/> Sore or burning tongue <input type="checkbox"/> Problems with teeth		
	<input type="checkbox"/> Changes in taste <input type="checkbox"/> Hoarseness <input type="checkbox"/> Frequent sore throats <input type="checkbox"/> Gingivitis		
NECK:	<input type="checkbox"/> Frequent stiffness <input type="checkbox"/> Goiter <input type="checkbox"/> Pain <input type="checkbox"/> Frequent swollen glands		
BREASTS:	<input type="checkbox"/> Tenderness <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Lumps or masses <input type="checkbox"/> Breast biopsy		
	<input type="checkbox"/> Family history of breast cancer. Who?		

RESPIRATORY:	<input type="checkbox"/> Cough <input type="checkbox"/> Coughing up blood or blood streaked phlegm <input type="checkbox"/> Pneumonia <input type="checkbox"/> Bronchitis		
	<input type="checkbox"/> Wheezing/asthma <input type="checkbox"/> Sputum (phlegm) production in the morning <input type="checkbox"/> Emphysema		
	<input type="checkbox"/> Coughing after eating		
CARDIOVASCULAR:	<input type="checkbox"/> Palpitations <input type="checkbox"/> Thumping in the chest <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Fainting spells		
	<input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Cramps in your legs on walking <input type="checkbox"/> Cramps in leg at night <input type="checkbox"/> Nocturnal cough		
	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chest pain or discomfort/angina <input type="checkbox"/> High blood pressure		
	<input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Heart murmur/abnormal heart valve		
	<input type="checkbox"/> Can you climb two flights of stairs without stopping? <input type="checkbox"/> Yes <input type="checkbox"/> No		
GASTROINTESTINAL:	<input type="checkbox"/> Pain <input type="checkbox"/> Heartburn <input type="checkbox"/> Intolerance to any foods <input type="checkbox"/> Vomiting		
	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Recent change in bowel habits <input type="checkbox"/> Jaundice		
	<input type="checkbox"/> Clay colored stools <input type="checkbox"/> Black or tarry stools <input type="checkbox"/> Blood in the stool or on toilet paper <input type="checkbox"/> Rectal itching		
	<input type="checkbox"/> Gall bladder trouble <input type="checkbox"/> Ulcers <input type="checkbox"/> Vomiting of blood or coffee ground-like material		
	<input type="checkbox"/> Liver disease <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Hiatal hernia <input type="checkbox"/> Pancreatitis		
	<input type="checkbox"/> Diverticulitis <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Esophagitis/reflux <input type="checkbox"/> Colon polyps		
	<input type="checkbox"/> Family history of colon cancer: <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Colonoscopy:	Date:	Gastroenterologist:
GENITOURINARY:	<input type="checkbox"/> Kidney Stones <input type="checkbox"/> Blood in urine <input type="checkbox"/> Coca cola colored urine <input type="checkbox"/> Urgency		
	<input type="checkbox"/> Burning <input type="checkbox"/> Straining on urination		
	How many times do you get up at night to urinate?		How long have you been doing this?
	MEN:	<input type="checkbox"/> Discharge from penis <input type="checkbox"/> Prostatitis <input type="checkbox"/> Pain or swelling	
		<input type="checkbox"/> Erectile dysfunction <input type="checkbox"/> Last PSA or rectal exam:	
	WOMEN:	<input type="checkbox"/> Discharge from vagina <input type="checkbox"/> Itching <input type="checkbox"/> Cramps	
		<input type="checkbox"/> Bleeding between periods	
	Date of last pelvic exam?		Date of last PAPS smear?
	Date of last menstrual period?		Do you use birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Onset age of menstrual period?		Days between periods?
	Duration of flow?		Date of last bone density exam?
PREGNANCIES?	How many pregnancies? Live births? Weight of largest baby?		
	During pregnancy, did you have any of the following?		
	<input type="checkbox"/> Diabetes <input type="checkbox"/> Seizures <input type="checkbox"/> High blood pressure <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Albumin or protein in urine		
MUSCULOSKELETAL:	<input type="checkbox"/> Arthritis <input type="checkbox"/> Joint stiffness in the morning <input type="checkbox"/> Bone pain <input type="checkbox"/> Muscle pain		
	<input type="checkbox"/> Swollen joints <input type="checkbox"/> Low back pain <input type="checkbox"/> Varicose veins <input type="checkbox"/> Phlebitis		
	<input type="checkbox"/> Cold or blue fingers <input type="checkbox"/> Rheumatoid arthritis		

NEUROLOGICAL:	<input type="checkbox"/> Seizures	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Stroke	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Muscle weakness
	<input type="checkbox"/> Tremors	<input type="checkbox"/> Muscle wasting	<input type="checkbox"/> Numbness	<input type="checkbox"/> Neuritis	<input type="checkbox"/> Fainting
GLANDS:	<input type="checkbox"/> Goiter	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Change in texture of hair	
BLOOD:	<input type="checkbox"/> Anemia	<input type="checkbox"/> Easy Bruisability	<input type="checkbox"/> Bleeding disorders		
PSYCHIATRIC:	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Hopeless feeling	<input type="checkbox"/> Feeling Blue	<input type="checkbox"/> Crying	
	<input type="checkbox"/> Shyness	<input type="checkbox"/> Difficulty relaxing	<input type="checkbox"/> Excess worrying	<input type="checkbox"/> Sexual problems	
	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Thoughts of suicide	<input type="checkbox"/> Loss of interest in pleasurable activities		
	Have you ever been hospitalized for emotional reasons? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Have you ever been on medication for emotional reasons? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Reason/diagnosis:				
	Have you ever been to see a psychiatrist or psychologist? <input type="checkbox"/> Yes <input type="checkbox"/> No				Name:

ALLERGIES ~ Please provide a complete list of all allergies:

Allergen (including medications)	Type of reaction:	Date of last reaction:

HABITS ~ Please indicate your average daily consumption of the following and how long you have used them:

Alcohol		Coffee	
Beer		Tea	
Wine		Cigarettes/ smokeless tobacco	
Marijuana		Pipes & cigars	

EMPLOYMENT

What type of work do you do?

What type of work does your spouse do?

IMMUNIZATIONS ~ Please indicate the last year you received each of the following immunizations:

Tetanus	
Infuenza (flu)	
Hepatitis B	
TB Skin Test	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Pneumonia	
Measles/Mumps/Rubella (MMR)	

