WASHINGTON MEDICAL GROUP, P.C.

Patient Questionnaire

Please Print Clearly

Name: _____ Date:_____ Age: _____

Specific reason for visit today (max 2): _____

_____

Date of Last Physical Examination:_____ Date of Last Menstrual Cycle: _____

Date of Onset (when symptoms began): _____ Allergies: _____

Current medications (include dosage and direction): _____

Tobacco usage: ___ yes ___ no. If yes, how much? _____ Employment: _____

Alcohol usage: ___ yes ___ no. If yes, # of drinks weekly? ___Highest level of education: _____

Medical History: YOU MUST COMPLETE THIS SECTION IF YOU ARE SEEING THE PROVIDER FOR THE FIRST TIME.

*Please check all that applies either to you or your family and give specific details.

	Patient	Family	Details/Type		Patient	Family	Details/Type
Accident:	☐	☐	_____	Kidney Disease:	☐	☐	_____
ADHD:	☐	☐	_____	Learning Disability:	☐	☐	_____
Arthritis:	☐	☐	_____	Liver Disease:	☐	☐	_____
Asthma:	☐	☐	_____	Lung Disease:	☐	☐	_____
Blood Disorder:	☐	☐	_____	Mental Illness:	☐	☐	_____
Cancer:	☐	☐	_____	Migraine:	☐	☐	_____
Dementia:	☐	☐	_____	Neurological Disease:	☐	☐	_____
Depression:	☐	☐	_____	Seizure:	☐	☐	_____
Diabetes:	☐	☐	_____	Sinusitis:	☐	☐	_____
Eye Disorder:	☐	☐	_____	Skin Disease:	☐	☐	_____
Glasses/contacts:	☐	☐	_____	Spine Disease:	☐	☐	_____
Head Trauma:	☐	☐	_____	Stomach Disease:	☐	☐	_____
Hearing Disorder:	☐	☐	_____	Stroke:	☐	☐	_____
Heart Disease:	☐	☐	_____	Thyroid Disease:	☐	☐	_____
High Cholesterol:	☐	☐	_____	Surgery:	☐	☐	_____
Hypertension:	☐	☐	_____	Other medical/illness history:			_____

Review of Systems: *Please check any CURRENT symptoms you are experiencing and/or what brought you in today.

Medical Visit:

General:
____Fatigue
____Fever
____Night Sweats
____Weight Gain > 10 lbs
____Weight Loss > 10 lbs

Skin:
____Change in Wart/Mole
____Itching
____New Lesions
____Rash

HEENT:
____Headache
____Visual Disturbances
____Hearing Loss
____Frequent Colds
____Bleeding Gums
____Hoarseness

Neck:
____Swollen Glands

Respiratory:
____Cough
____Difficulty breathing

Breast:
____Breast Mass
____Breast Pain
____Nipple Discharge
____Skin Changes

Cardiovascular:
____Chest Pain
____Shortness of Breath
____Swelling of Extremities

Gastrointestinal:
____Abdominal Pain
____Constipation

Gastrointestinal: cont.
____Diarrhea
____Difficulty swallowing
____Rectal bleeding

Female Genitourinary:
____Frequency
____Menstrual Irregularities
____Painful Urination
____Pelvic Pain
____Urgency
____Vaginal Discharge

Musculoskeletal:
____Calf Pain
____Joint Pain
____Muscle Cramp

Neurological:
____Dizziness
____Numbness
____Weakness

Psychiatric:
____Anxiety
____Change in Sleep Pattern
____Mood changes

Endocrine:
____Cold Intolerance
____Excessive Thirst
____Excessive Urination
____Heat Intolerance

Hematology:
____Easy bruising
____Enlarged Lymph Nodes
____Prolonged Bleeding

Neurology Visit:

General:
____Appetite Loss
____Chills
____ Dietary Changes
____ Fatigue
____Fever
____Lethargy
____Night Sweats
____Weight change □ gained ___ lbs
□ loss ____ lbs

Skin:
____Bruising
____Excessive Sweating
____Hair Loss
____ Hives
____Itching
____New Lesions
____Rash

HEENT:
____Headache
____Head Injury
____Blurred Vision
____Double Vision
____Eye Pain
____Visual Disturbances
____Decreased Hearing
____Ear Pain
____Ringing in the Ears
____Vertigo
____Nose Bleed
____Nasal Congestion
____Sinus Pain
____Hoarseness
____Voice Changes
____Decreased sense of taste

Neck:
____Neck Pain
____Neck Stiffness
____Swollen Glands

Cardiovascular:
____Chest Pain
____Fainting
____Leg Cramps
____Palpitations
____Rapid Heart Rate
____Shortness of Breath
____Swelling of Extremities

Musculoskeletal:
____Back Pain
____Decreased Range of Motion
____Joint Pain
____Joint Redness
____Joint Stiffness
____Joint Swelling
____Muscle Atrophy
____Muscle Cramps
____Muscle Pain
____Muscle Weakness

Neurological
____Attention Deficit
____Auras
____Decreased Memory
____Difficulty Speaking
____Dizziness
____Easily Distracted
____Fasciculation
____Fainting
____Headaches
____Hyperactivity

Neurological: cont.
____Loss of Consciousness
____Numbness
____Seizures
____Spinning Sensation
____Tremor
____Visual Changes
____Weakness
____Tingling

Psychiatric:
____Anxiety
____Change in Sleep Pattern
____Depression
____Early Awakening
____Easily Irritated
____Fearful
____Frequent crying
____Impaired Cognitive Function
____Inability to Concentrate
____Insomnia
____Memory Loss
____Mood Changes
____Panic Attacks
____Suicidal Ideation

Endocrine:
____Appetite Changes
____Cold Intolerance
____Hair Changes
____Sexual Dysfunction