

**Cypress Physicians Association
Adult Medical Questionnaire**

Patient Name: _____ Date of Birth: _____
 Previous Physician: _____ Today's Date: _____

Reason for today's visit	Date problem began (if applicable)

Past Medical History: Please mark if you or your family members have had any of the following:						
	Self	Father	Mother	Sibling	Child	Others
High blood pressure						
Heart blockage/attack/stent						
Heart disease						
Arrhythmia						
High cholesterol						
Diabetes						
Thyroid problems						
Cancer (type)						
COPD/emphysema						
Asthma						
Sleep Apnea						
Stomach Ulcers						
Seizures						
Migraines						
Depression						
Anxiety						
Other psychiatric illness						
Alcoholism						
Kidney problems						
Stroke or TIA						
Allergies/hayfever						
Arthritis						
Osteoporosis/fracture						
Other:						

Surgical History: Please mark if you have had any of these surgeries (what YEAR)	
Heart bypass	
Angioplasty/stents	
Pacemaker	
Appendix removal	
Gallbladder removal	
Tonsil removal	
Hernia repair	
Back surgery	
Joint surgery (type)	
C-section	
Tubal ligation	
Hysterectomy	
Vasectomy	
Breast augmentation	
Mastectomy	
Breast lump removal	
Cataracts	
Other:	

MEDICATIONS: Please list all prescription, over-the-counter, or herbal supplements you are taking				
Medication	Dosage	Frequency	Purpose/Use	Need refill today?

Allergies to Medication/Food/Other: PLEASE DESCRIBE THE REACTION (rash, nausea, etc)	
Pharmacy Local:	Mail:

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Review of Systems: Are you CURRENTLY having any of the following symptoms?					
Fever		Cough		Arm/leg weakness	
Chills		Wheezing		Joint pain	
Weight Loss		Short of breath		Muscle pain	
Weight Gain				Leg Pain	
Fatigue		Nausea/Vomiting		Back pain	
Swollen Glands		Diarrhea		Numbness/tingling	
		Constipation		Difficulty walking	
Double vision		Abdominal pain			
Blurred/Poor Vision		Difficulty swallowing		Fainting spells	
Eye pain		Heartburn		Headaches	
ringing in ears		Bloody/black stools		Dizziness	
Ear pain		Hemorrhoids		Seizures	
Nose bleeds		Loss of appetite			
Decreased hearing				Depression/anxiety	
Sinus pain/drainage		Urinate at night		Sleeping difficulty	
Sore throat		Urgency to urinate		Memory problems	
		Blood in urine		Suicidal thoughts	
Chest Pain		Incontinence		Concentration difficulty	
Palpitations		Pain/burn with urinating			
Irregular pulse				Infertility	
Leg swelling		Rashes/Hives		Vaginal discharge	
Varicose veins		Nail fungus		Breast pain	
Snoring		Changing mole		Erectile dysfunction	

Alcohol (amount/type/frequency)	Coffee/Tea/Caffeine (cups/day)	Smoking Packs/day _____ # of years _____		
Year of last vaccine	Flu	Tetanus/TD	Pneumonia	Shingles
Concerns about safety or abuse at home?			Occupation:	
Marital Status:		# of children:		

Year of last test (Please check if test was abnormal)	Prostate	Colonoscopy	Cardiac stress test
	TB Test	Eye exam	Dental exam
	Bone Density	Mammogram	Pap smear

Females				
Menstrual flow:		Days of flow:	Days between menses:	
1 st day of last cycle:	Number of pregnancies:	Number of live births:	Number of abortions:	Number of Miscarriages:
Pain after sex:	Birth control:	Type of birth control:	Name of Birth control:	

List any other physicians that you see/ Specialty	