**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? |
| | | | | Yes No |
| | | | | Yes No |
| | | | | Yes No |
| | | | | Yes No |
| | | | | Yes No |
| | | | | Yes No |

| **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** Current Past/Quit No Packs/day _____ # of years _____ |
|---|---|---|

| **Year of last vaccine** | **Flu** | **Tetanus/TD** | **Pneumonia** | **Shingles** |
|---|---|---|---|---|

| **Concerns about safety or abuse at home? Yes / No** | **Occupation:** |
|---|---|
| **Married Single Widowed Divorced** | **# of children:** |

| **Year of last test (Please circle if test was abnormal)** | Prostate (males) | Colonoscopy | Cardiac stress test |
|---|---|---|---|
| | TB Test | Eye exam | Dental exam |
| | Bone Density | Mammogram | Pap smear (female) |

| **Females** | | | | |
|---|---|---|---|---|
| Menstrual flow: Regular Irregular Heavy | | Days of flow: | Days between menses: | |
| 1st day of last cycle: | Number of pregnancies: | Number of live births: | Number of abortions: | Number of Miscarriages: |
| Pain after sex: Yes No | Birth control: Yes No | Type of birth control: | Name of Birth control: | |

| **List any other physicians that you see/ Specialty** | |
|---|---|
| | |