**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 |
| | | | | Yes |
| | | | | Yes |
| | | | | Yes |
| | | | | Yes |
| | | | | Yes |

| **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** Past/Quit<br>Packs/day _____ # of years _____ |
|---|---|---|

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

| **Concerns about safety or abuse at home?** No | **Occupation:** |
|---|---|
| **Marital Status:** Married | **# 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: Regular | | 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: | Birth control: | Type of birth control: | Name of Birth control: | |

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