REJENESIS
HEALTH + WELLNESS

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Patient Medical Questionnaire-Confidential

Name:_____ Date of Birth:_____ Age:_____ Sex: ☐M ☐F

Phone: Home:_____ Work:_____ Cell:_____

Years of school (circle one): 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Marital Status (circle one): Single Married Remarried Divorced Widowed Separated

How many years? _____ _____ _____ _____ _____ _____

Current Occupation:_____ Location:_ Years:_____

Previous/other occupations, hobbies:_____

Exposure to hazardous materials: ☐ Yes ☐ No Type:_____

Last date worked:_____ Are you disabled from work? ☐ Yes ☐ No

Reason:_____

Spouse's Name: _____ Spouse's current occupation:_____

Spouse's previous occupations, hobbies:_____

Please list any other health care providers you are currently seeing:

_____ Date last seen:_____

_____ Date last seen:_____

_____ Date last seen:_____

What is the reason that brings you to our office: ☐ CARE visit ☐ Establishing care ☐ Problem(s)

Describe the problem(s) you are here for:_____

How long have you had the problem(s)?:_____

PAST MAJOR MEDICAL HISTORY:

Year	Procedure or Problem	Place of Hospitalization

PATIENTS MEDICAL HISTORY: Have you ever had or are you being treated for. . .

☐ Asthma, emphysema, or COPD
☐ Pneumonia
☐ Heart attack or chest pain
☐ Heart murmur
☐ High blood pressure
☐ Phlebitis or blood clots
☐ Stroke
☐ Migraine or severe head pain
☐ Nervous or psychiatric condition: _____
☐ Alcoholism or drug addiction

☐ Hepatitis
☐ Ulcer
☐ Colon Polyps
☐ Kidney disease or stones
☐ Bladder or kidney infection
☐ Urinary retention or incontinence
☐ Diabetes
☐ High cholesterol or triglycerides
☐ Thyroid condition
☐ Cancer: site_____
☐ *Surgery* ☐ *Radiation* ☐ *Chemotherapy*

☐ Sexually transmitted disease(s): _____
☐ AIDS or HIV testing
☐ Blood transfusion
☐ Herpes or shingles
☐ Polio
☐ Rheumatic Fever
☐ Tuberculosis
☐ Other:_____

Family History: List all immediate family members, including your family-of-origin. If family member is deceased, please list age at time of death and cause of death.

	Living?	Age	Known Medical Conditions or Cause of Death
Spouse:			
Children:			
Mother:			
Father:			
Sister(s):			
Brother(s):			

Is there a history of any of the following in a blood relative (parents, grandparents, siblings, aunts, uncles, etc.)?

- ☐ Alcohol/drug addiction
- ☐ Aneurysm
- ☐ Arthritis
- ☐ Asthma/emphysema
- ☐ Breast cancer
- ☐ Colon cancer
- ☐ Other cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart attacks/angioplasty
- ☐ Heart Surgery
- ☐ High blood pressure
- ☐ High cholesterol/triglyceride
- ☐ Kidney disease
- ☐ Kidney failure
- ☐ Kidney stones
- ☐ Liver problems
- ☐ Migraine headaches
- ☐ Nervous breakdown
- ☐ Psychiatric condition(s) _____
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Other major conditions *(list)*

MEDICATIONS: List all medications you've been taking recently. Include over-the-counter medicines and supplements.

****PLEASE BRING ALL MEDICINE****

Name Dose(mgs & times per day) Date Started Date Stopped

1._____
2._____
3._____
4._____

Name Dose(mgs & times per day) Date Started Date Stopped

5._____
6._____
7._____
8._____

Have you used "recreational" drugs? ☐ YES ☐ NO What/When?_____

ALLERGIES or reactions to medicine or other substances. List all medications and substances.

Name of Medication/Substance Type of Reactions

1._____
2._____
3._____

Name of Medication/Substance Type of Reactions

4._____
5._____
6._____

IMMUNIZATIONS/VACCINES and Dates

Pneumonia (Pneumovax)_____ H1N1 Flu_____

Measles_____ Seasonal Flu_____

Tetanus_____ Herpes Zoster (Shingles)_____

Hepatitis_____ COVID-19 1ST_____ 2ND_____ 3RD_____

PREVIOUS STUDIES/APPROXIMATE DATE: Please bring copies of recent test and x-ray results, if available.

☐ Chest X ray_____ ☐ Cat Scan_____ ☐ Bronchoscopy_____

☐ Kidney/IVP_____ ☐ PAP_____ ☐ Echocardiogram_____

☐ Stomach/UGI_____ ☐ PSA_____ ☐ MRI_____

☐ Ultrasound of_____ ☐ Colon/Barium Enema_____ ☐ Proctoscopy_____

☐ Stress test_____ ☐ Gall Bladder_____ ☐ Gastroscopy_____

☐ EKG_____ ☐ Mammogram_____ ☐ Colonoscopy_____

☐ Pulmonary Function_____ ☐ Prostate Exam_____ ☐ Biopsy of_____

☐ Cystoscopy_____ ☐ Other_____

PERSONAL HABITS AND LIFESTYLE

Tobacco: Have you ever used tobacco products? ☐ Yes ☐ No

Type:_____ Amount per day:_____Years used:_____If you've quit, when?_____

Type:_____ Amount per day:_____Years used:_____If you've quit, when?_____

If currently using, have you tried to stop? ☐ Yes ☐ No Do you wish to stop? ☐ Yes ☐ No

Alcohol: Amount consumed (including beer, wine and liquor):_____drinks per day, _____times per week

Have you ever felt you should cut down on your drinking? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking? ☐Yes ☐ No

Have you ever felt bad or guilty about your drinking? ☐ Yes ☐ No

Have you ever had a drink in the morning to steady your nerves or get rid of a hangover? ☐ Yes ☐ No

Have you had a problem with your drinking? ☐ Yes ☐ No

Coffee, Tea and Cola Beverages: Amount per day?_____

Travel: Where and when in the last 2 years?_____

Diet: Any special diets or changes in eating habits?_____

Exercise: Any exercise? ☐Walking ☐Sports_____ ☐Other_____

Sleep: Average # hrs sleep/night___Do you have a regular bedtime/wake time? ___/___ Do you nap?☐Yes ☐No

Safety: Do you wear a seat belt? ☐ Yes ☐ No

If you participate in high-risk activities such as flying, parasailing, etc., please list_____

Advanced Directive:

Do you have a Living Will? ☐Yes ☐No Date:_____

Do you have a Power of Attorney or Health Care Power of Attorney? ☐Yes ☐No Date:_____

If you answered "yes" to either of these questions, please bring copies for your patient record.

CURRENT/RECENT MEDICAL CONDITIONS AND REVIEW OF SYSTEMS	***Please do not write in this space***
Is the purpose of this examination to determine disability? ☐Yes ☐No Have you had an injury for which there is now a Lawsuit pending? ☐Yes ☐No	
Do you have any of the following:	
Recent weight gain? (amount)_____ ☐ Yes ☐ No	
Recent weight loss? (amount)_____ ☐ Yes ☐ No	
Fever or soaking sweats at night? ☐ Yes ☐ No	
Fatigue? ☐ Yes ☐ No	
Weakness, numbness, tingling or night cramps of arms or legs? ☐ Yes ☐ No	
New, frequent or severe headaches? ☐ Yes ☐ No	
Falls, imbalance or difficulty walking? ☐ Yes ☐ No	
Loss of consciousness, fainting or convulsions? ☐ Yes ☐ No	
Loss of memory or confusion? ☐ Yes ☐ No	
Problem with vision or eyes? ☐Yes ☐No Date/Provider of last eye exam?_____/_____	
Do you wear glasses or contact lenses? ☐Yes ☐No	
Head or ear noises? ☐ Yes ☐ No	
Change in hearing? ☐ Yes ☐ No	
Do you use a hearing aid? ☐ Yes ☐ No	
Change in speech or voice? ☐ Yes ☐ No	
Dizziness?(☐ Spinning ☐ Lightheadedness) ☐ Yes ☐ No	
Frequent or severe nosebleeds? ☐ Yes ☐ No	
Trouble chewing or swallowing? ☐ Yes ☐ No	
Sore tongue or mouth or dental problems? ☐ Yes ☐ No	

Daily cough or cough with bloody phlegm?	☐Yes ☐No	***Please do not write in this space***
Abdominal pain?	☐ Yes ☐No	
Frequent heartburn or indigestion?	☐ Yes ☐No	
Change in bowel habits?	☐ Yes ☐No	
Black or bloody bowel movements?	☐ Yes ☐No	
Difficulty urinating?	☐ Yes ☐No	
Do you lose control of urine at times?	☐ Yes ☐No	
Awaken at night more than once to urinate?	☐ Yes ☐No	
Sexual problems or change in sex drive?	☐ Yes ☐No	
Do you have any discharge	☐ Yes ☐No	
Any changes in skin, moles, rash?	☐ Yes ☐No	
Persistent painful, stiff or swollen joints?	☐ Yes ☐No	
Back pain or discomfort?	☐ Yes ☐No	
Do you enjoy your work?	☐ Yes ☐No	
How many people in your household?	_____	
Any stress or frequent conflicts at home?	☐ Yes ☐No	
Do you feel anxious or depressed much of the time?	☐ Yes ☐No	
Have you seriously considered suicide?	☐ Yes ☐No	
Difficulty in sleeping?	☐ Yes ☐No	
WOMEN ONLY:		
Are your menstrual periods normal?	☐ Yes ☐No	
Date of last menstrual period?	☐ Yes ☐No	
Bleeding between periods or after menopause?	☐ Yes ☐No	
Any “hot flashes”?	☐ Yes ☐No	
Any pain or dryness with intercourse?	☐ Yes ☐No	
Any breast discharge?	☐ Yes ☐No	
Pregnancies_____ Deliveries_____		
Miscarriages_____Abortions_____		
Approximate date of last PAP smear:_____		
Have you used hormones?	☐Yes ☐No	

Name of preferred Pharmacy_____

Have we left anything out that you are concerned about or feel is important about your health? _____

_____

_____

_____

_____

_____ _____ _____

Patient Signature *Date* *Reviewed by Physician*