

<p>The University of Texas SOUTHWESTERN MEDICAL CENTER At Dallas</p> <p style="text-align: center;"><b>Confidential Health Questionnaire</b></p>	<p>Patient Information Label</p>
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Date: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Patient's Current Occupation: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Marital Status:  Married  Single  Widowed

Name of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

***If the patient is a minor, please provide the information below:***

Parent: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_  
 Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

With whom does the child reside: \_\_\_\_\_ Relationship: \_\_\_\_\_

Preferred Pharmacy #: \_\_\_\_\_

Current Medications: \_\_\_\_\_  
 \_\_\_\_\_

Herbal products/diet supplements: \_\_\_\_\_

Allergies: \_\_\_\_\_

Past Surgeries & Dates: \_\_\_\_\_  
 \_\_\_\_\_

*Please describe:*

Are you on a special diet? (i.e., low salt, low cholesterol)  No  Yes \_\_\_\_\_

Do you exercise regularly?  No  Yes \_\_\_\_\_

Do you routinely wear a seat belt?  No  Yes \_\_\_\_\_

Do you have any metal in your body?  No  Yes \_\_\_\_\_

Do you have a pacemaker?  No  Yes \_\_\_\_\_

Do you use tobacco?  No  Yes \_\_\_\_\_

Packs per day: \_\_\_\_\_ Year started: \_\_\_\_\_ Year stopped: \_\_\_\_\_ Type of tobacco: \_\_\_\_\_

Do you drink alcohol?  No  Yes \_\_\_\_\_

Drinks per day: \_\_\_\_\_ Per week: \_\_\_\_\_

Do you use recreational drugs?  No  Yes \_\_\_\_\_

***Females:***

Last menstrual period date: \_\_\_\_\_ Number of pregnancies: \_\_\_\_\_ Number of live births: \_\_\_\_\_

Do you do breast exams regularly?  No  Yes

***Males:***

Do you do testicular self exams regularly?  No  Yes

**Family History**

Please indicate whether a blood relative has had any of the following:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Cancer _____   | <input type="checkbox"/> Heart Attack _____        | <input type="checkbox"/> Lung Disease _____       |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Neurologic Disease _____ |
| <input type="checkbox"/> Gout _____     | <input type="checkbox"/> Kidney Disease _____      | <input type="checkbox"/> Other _____              |

**Do you have now, or have you been diagnosed as having: (If yes, please explain and provide dates)**

- |                                       |                             |                              |       |
|---------------------------------------|-----------------------------|------------------------------|-------|
| Stroke or "shock"                     | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Anemia                                | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Angina or chest pain                  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Arthritis                             | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Cancer or tumor                       | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Diabetes mellitus                     | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Heart attack                          | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Heart failure                         | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| High blood pressure                   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Irregular or rapid heart beat         | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Kidney stones or other disease        | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Nervous breakdown                     | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Other medical problems                | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Stomach or duodenal ulcer             | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Thyroid disease                       | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Varicose veins or blood clots in legs | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |

**Have you experienced any of the following since your last visit: (Check all that apply)**

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Seizures                   | <input type="checkbox"/> Visual problems         | <input type="checkbox"/> Blood in stool              | <input type="checkbox"/> Intolerance to cold/heat |
| <input type="checkbox"/> Headache                   | <input type="checkbox"/> Redness                 | <input type="checkbox"/> Abdominal pain              | <input type="checkbox"/> Hot flashes              |
| <input type="checkbox"/> Hearing loss               | <input type="checkbox"/> Pain                    | <input type="checkbox"/> Change in bowel habits      | <input type="checkbox"/> Weakness                 |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Tearing                 | <input type="checkbox"/> Constipation                | <input type="checkbox"/> Weight gain/loss         |
| <input type="checkbox"/> Hay fever                  | <input type="checkbox"/> Discharge               | <input type="checkbox"/> Diarrhea                    | <input type="checkbox"/> Rashes                   |
| <input type="checkbox"/> Memory problems            | <input type="checkbox"/> Thyroid problems        | <input type="checkbox"/> Rectal pain                 | <input type="checkbox"/> Itching/dryness          |
| <input type="checkbox"/> Cough                      | <input type="checkbox"/> Chest pain              | <input type="checkbox"/> Jaundice                    | <input type="checkbox"/> New/different moles      |
| <input type="checkbox"/> Congestion                 | <input type="checkbox"/> Palpitations            | <input type="checkbox"/> Hemorrhoids                 | <input type="checkbox"/> Hair loss                |
| <input type="checkbox"/> Coughing up blood          | <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Involuntary loss of urine   | <input type="checkbox"/> Depression               |
| <input type="checkbox"/> Difficulty chewing         | <input type="checkbox"/> Swelling in extremities | <input type="checkbox"/> Kidney stones               | <input type="checkbox"/> Mood disturbance         |
| <input type="checkbox"/> Difficulty with speech     | <input type="checkbox"/> Leg cramps              | <input type="checkbox"/> Sexual problems             | <input type="checkbox"/> Hallucinations           |
| <input type="checkbox"/> Difficulty with swallowing | <input type="checkbox"/> Heart murmurs           | <input type="checkbox"/> Genital lesions             | <input type="checkbox"/> Anxiety                  |
| <input type="checkbox"/> Sore throats               | <input type="checkbox"/> Shortness of breath     | <input type="checkbox"/> Discharge                   | <input type="checkbox"/> Other pain               |
| <input type="checkbox"/> Voice changes              | <input type="checkbox"/> Bronchitis              | <input type="checkbox"/> Itching                     |   |
| <input type="checkbox"/> Bleeding gums              | <input type="checkbox"/> Pneumonia               | <input type="checkbox"/> Painful intercourse         |   |
| <input type="checkbox"/> Fainting                   | <input type="checkbox"/> Wheezing                | <input type="checkbox"/> Heavy menstrual cycles      |   |
| <input type="checkbox"/> Falls                      | <input type="checkbox"/> TB exposure             | <input type="checkbox"/> Difficulty sleeping         |   |
| <input type="checkbox"/> Dizziness                  | <input type="checkbox"/> Colored sputum          | <input type="checkbox"/> Excessive fatigue/tiredness |   |
| <input type="checkbox"/> Loss of balance            | <input type="checkbox"/> Nausea/vomiting         | <input type="checkbox"/> Muscle aches                |   |
| <input type="checkbox"/> Tingling                   | <input type="checkbox"/> Heartburn               | <input type="checkbox"/> Stiffness                   |   |
| <input type="checkbox"/> Tremors                    | <input type="checkbox"/> Hernias                 | <input type="checkbox"/> Back pain                   |   |
| <input type="checkbox"/> Fever                      | <input type="checkbox"/> Change in appetite      | <input type="checkbox"/> Neck pain                   |   |
| <input type="checkbox"/> Chills                     | <input type="checkbox"/> Easy bruising           | <input type="checkbox"/> Gout                        |   |
| <input type="checkbox"/> Excessive thirst           | <input type="checkbox"/> Excessive bleeding      | <input type="checkbox"/> Arthritis                   |   |
| <input type="checkbox"/> Hoarseness                 | <input type="checkbox"/> Frequent urination      | <input type="checkbox"/> Joint pain                  |   |
| <input type="checkbox"/> Snoring                    | <input type="checkbox"/> Painful urination       | <input type="checkbox"/> Paralysis                   |   |
| <input type="checkbox"/> Nose bleeds                | <input type="checkbox"/> Frequent infections     | <input type="checkbox"/> Numbness                    |   |
| <input type="checkbox"/> Ringing in ears            | <input type="checkbox"/> Blood in urine          | <input type="checkbox"/> Night sweats                |   |

**Mark Items you would like to discuss with your physician:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Weight management or diet        | <input type="checkbox"/> Alcohol or other drug use              | <input type="checkbox"/> Smoking cessation              |
| <input type="checkbox"/> Sexual and reproductive health   | <input type="checkbox"/> Depression, stress, or anxiety         | <input type="checkbox"/> Osteoporosis                   |
| <input type="checkbox"/> Exercise, cardiovascular fitness | <input type="checkbox"/> Breast self-examination                | <input type="checkbox"/> Accident prevention and safety |
| <input type="checkbox"/> Herbs, non-prescription remedies | <input type="checkbox"/> Menopause, hormone replacement therapy |   |
| <input type="checkbox"/> Other (please describe) _____    |   |   |

**Have you had the following immunizations?**

- |                                      |                                  |                                     |  |
|--------------------------------------|----------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Tetanus | <input type="checkbox"/> Flu        | <input type="checkbox"/> Pneumonia Date: _____ |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> TB      | <input type="checkbox"/> Etc. _____ |  |

**(Print) Completed by patient or caregiver:** \_\_\_\_\_

**Signature of patient or caregiver:** \_\_\_\_\_

**I have read & reviewed:** \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_