Atlantic
Health System
Atlantic Medical Group

Date: ________________

Patient Name:____________________________________

MEDICAL QUESTIONNAIRE

PATIENT INFORMATION:		
Last Name:	First Name:	Date of Birth:
Address:	City:	State: Zip:
Home Phone:	Cell Phone:	
E-Mail Address:	Sex:	Religion:
Employer:	Occupation:	Work Phone:
Primary Language:	Ethnic Origin:	Race:
EMERGENCY CONTACT INFORMATION:		
Name:	Relationship:	Phone:

Can we leave a message on home/cell phone with test results? HOME: ☐ YES ☐ NO CELL: ☐ YES ☐ NO

Can we speak to a family member about your care and test results? ☐ YES ☐ NO

If yes, please list name(s): ____

PRIMARY INSURANCE:		
POLICY HOLDER:		
Last Name:	First Name:	Date of Birth:
Address:	City:	State: Zip:
Relationship to Patient:	Social Security Number:	
Employer:	Employer Phone Number:	
Address:	City:	State: Zip:
Insurance Name:		
Address:	City:	State: Zip:
Insurance ID#:	Group #:	
SECONDARY INSURANCE:		
POLICY HOLDER		
Last Name:	First Name:	Date of Birth:
Address:	City:	State: Zip:
Relationship to Patient:	Social Security Number:	
Employer:	Employer Phone Number:	
Address:	City:	State: Zip:
Insurance Name:		
Address:	City:	State: Zip:
Insurance ID#:	Group #:	

Physician Signature: ____ Date: ____________ Time: ____________

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Primary Care Physician: ____ Phone: ________________

Referring Doctor: ____ Phone: ________________

Do you have a living will / advance directive? ☐ YES ☐ NO

If yes, please provide us a copy to file in your medical chart.

If no, would you like to be provided with this information? ☐ YES ☐ NO

REASON FOR VISIT: **Date of Injury (if pertinent):** ____________________

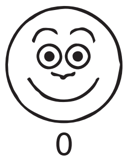
____

____

Please list your present health concerns, problems or symptoms: ________________________________

____

____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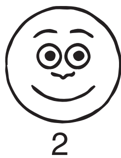
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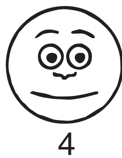
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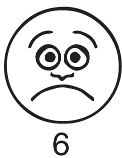
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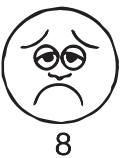
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Are you having pain? ☐ YES ☐ NO

If yes, what level? ______________________________

Where? ______________________________________

ALLERGIES or intolerance to medications (include type of reaction): ________________________________

____

____

____ ☐ **NONE**

NAME OF MEDICATION INCLUDE -VITAMINS-HERBS & OVER THE COUNTER ☐ **CHECK BOX IF YOU TAKE NO MEDICATIONS**	**DOSAGE** mg/units puffs/drops	**FREQUENCY** How many times a day? Morning and/or night? After meals?	DO YOU NEED REFILLS?

Pharmacy: ________________________ Location: ____ Phone: ________________

Physician Signature: ____ Date: ____________ Time: ____________

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VACCINATIONS:

Check if you have had the following and include the date (if known):

☐ Tetanus _______________ ☐ Flu _______________ ☐ Pneumonia _______________

☐ Hepatitis A _______________ ☐ Hepatitis B _______________ ☐ Shingles _______________

☐ Positive PPD or Mantoux (Tuberculosis Skin Test) _______________

PAST MEDICAL HISTORY: PLEASE CHECK WHETHER YOU HAVE EVER HAD THE FOLLOWING:

	NO	YES		NO	YES		NO	YES
Anemia	☐	☐	Diabetes mellitus	☐	☐	Nerve/muscle disease	☐	☐
Anxiety	☐	☐	Emphysema	☐	☐	Osteoporosis	☐	☐
Arthritis	☐	☐	GERD	☐	☐	Other cancer	☐	☐
Asthma	☐	☐	Glaucoma	☐	☐	Seizures	☐	☐
Atrial fibrillation	☐	☐	Heart murmur	☐	☐	Sickle cell anemia	☐	☐
Cancer	☐	☐	Hepatitis	☐	☐	Stroke	☐	☐
Cataracts	☐	☐	HIV/AIDS	☐	☐	Substance abuse	☐	☐
CHF	☐	☐	Hyperlipidemia	☐	☐	Thyroid disease	☐	☐
Clotting disorder	☐	☐	Hypertension	☐	☐	Tuberculosis	☐	☐
COPD	☐	☐	Kidney disease	☐	☐	Ulcers (GI)	☐	☐
Dementia	☐	☐	Meningitis	☐	☐	Vitamin D deficiency	☐	☐
Depression	☐	☐	Myocardial infarction	☐	☐	Other:	☐	☐

Have you ever had surgery? ☐ YES ☐ NO

PAST SURGICAL HISTORY: PLEASE CHECK WHETHER YOU HAVE EVER HAD THE FOLLOWING:

	NO	YES		NO	YES		NO	YES
Appendectomy	☐	☐	C-Section	☐	☐	Small intestine surgery	☐	☐
Brain surgery	☐	☐	Eye surgery	☐	☐	Spine surgery	☐	☐
Breast surgery	☐	☐	Fracture surgery	☐	☐	Tonsillectomy	☐	☐
CABG	☐	☐	Hernia repair	☐	☐	Tubal ligation	☐	☐
Cholecystectomy	☐	☐	Hysterectomy	☐	☐	Valve replacement	☐	☐
Colon surgery	☐	☐	Joint replacement	☐	☐	Vasectomy	☐	☐
Cosmetic surgery	☐	☐	Prostate surgery	☐	☐	Other:	☐	☐

FAMILY HISTORY:	AGE IF LIVING	AGE AT DEATH	HEALTH PROBLEMS OR CAUSE OF DEATH
MOTHER:			
FATHER:			
BROTHERS:			
SISTERS:			
CHILDREN:			

Physician Signature: ____ Date: ___________ Time: ___________

Date: _______________

Patient Name:___________________________________

SOCIAL HISTORY:

Tobacco: What is your current smoking status? ☐ CURRENT SMOKER ☐ FORMER SMOKER ☐ NEVER SMOKER

If current smoker, how many per day? _______________

If former smoker, when did you quit? _____ / _____ / _____

Alcohol: Do you drink wine, beer or liquor? ☐ YES ☐ NO

If yes, how many drinks per week? _______________

Drugs: Do you currently use recreational drugs? ☐ YES ☐ NO

If yes, what types? ____

How often per week? ____________

Sexual Activity: Are you sexually active? ☐ YES ☐ NO ☐ NOT CURRENTLY

Your sexual partners are: ☐ MALE ☐ FEMALE ☐ BOTH

What forms of birth control/protection are you using? ____

HEALTH MAINTENANCE: List dates of the most recent preventive services you have received below

Test	Date of Last Test	Never Performed
Colonoscopy	_____________________________	☐
Dexa Bone Scan	_____________________________	☐
Eye (Ophthalmology) Exam	_____________________________	☐
Hemoglobin A1C (blood test)	_____________________________	☐
Urine Sample	_____________________________	☐
Pap Smear	_____________________________	☐
Mammogram	_____________________________	☐

FALL ASSESSMENT:

Have you had any falls in the past year? ☐ YES ☐ NO ☐ NO, I AM NOT AMBULATORY

If yes, what is the number of falls in the past year? _________

Was there an injury with the fall? ☐ YES ☐ NO

LEARNING NEEDS ASSESSMENT:

Who is the Primary Learner? ☐ SELF ☐ FAMILY ☐ SIGNIFICANT OTHER ☐ CAREGIVER

Does the Primary Learner have any learning barriers? ☐ YES ☐ NO

If yes, please select all the barriers that apply: ☐ READING ☐ LANGUAGE ☐ VISUAL HEARING ☐ PHYSICAL

☐ EMOTIONAL ☐ COGNITIVE ☐ FINANCIAL ☐ SPIRITUAL ☐ CULTURAL ☐ OTHER

What is the preferred language of the Primary Learner? ____

How does the Primary Learner prefer to learn new concepts? ☐ LISTENING ☐ READING ☐ DEMONSTRATION

☐ PICTURES/VIDEO

Physician Signature: ____ Date: ____________ Time: ____________

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WOMEN'S HEALTH HISTORY (if applicable):

Total number of pregnancies: _______________ Number of births: _______________

Date of last menstrual period, if you are still menstruating: _______________

Age of your first period (menstruation): _______________

Age that your periods ceased (menopause): _______________

Date of last mammogram: _______________ Abnormal? ☐ YES ☐ NO

Date of last pap smear: _________________ Abnormal? ☐ YES ☐ NO

Date of last bone density: _______________ Abnormal? ☐ YES ☐ NO

Have you ever used birth control pills? ☐ YES ☐ NO If yes, how long? _____________________

Have you ever taken hormone replacement therapy? ☐ YES ☐ NO If yes, how long? _____________________

Have you ever been given fertility drugs? ☐ YES ☐ NO If yes, how long? _____________________

Have you ever used Tamoxifen or Raloxifen, or similar medication? ☐ YES ☐ NO If yes, how long? _____________________

Are your ancestors of Ashkenazi descent? ☐ YES ☐ NO

REVIEW OF SYSTEMS: Please indicate any personal history below

CONSTITUTION:	NO	YES
Activity change	☐	☐
Appetite change	☐	☐
Chills	☐	☐
Increase sweating	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Unexpected weight	☐	☐

HEAD/EARS/NOSE/THROAT:	NO	YES
Congestion	☐	☐
Dental problem	☐	☐
Drooling	☐	☐
Ear discharge	☐	☐
Ear pain	☐	☐
Facial swelling	☐	☐
Hearing loss	☐	☐
Mouth sores	☐	☐
Nosebleeds	☐	☐
Postnasal drip	☐	☐
Rhinorrhea	☐	☐
Sinus pressure	☐	☐
Sneezing	☐	☐
Sore throat	☐	☐
Tinnitus	☐	☐
Trouble swallowing	☐	☐
Voice change	☐	☐

EYES:	NO	YES
Eye discharge	☐	☐
Eye itching	☐	☐
Eye pain	☐	☐
Eye redness	☐	☐
Light sensitivity	☐	☐
Visual disturbances	☐	☐

RESPIRATORY:	NO	YES
Apnea	☐	☐
Chest tightness	☐	☐
Choking	☐	☐
Cough	☐	☐
Shortness of breath	☐	☐
Stridor	☐	☐
Wheezing	☐	☐

CARDIOVASCULAR:	NO	YES
Chest pain	☐	☐
Leg swelling	☐	☐
Palpitations	☐	☐

Physician Signature: ____ Date: ____________ Time: ____________

Date: ________________

Patient Name:___________________________________

REVIEW OF SYSTEMS (continued): Please indicate any personal history below

GASTROINTESTINAL:	NO	YES
Abdominal distention	☐	☐
Abdominal pain	☐	☐
Anal bleeding	☐	☐
Blood in stool	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Nausea	☐	☐
Rectal pain	☐	☐
Vomiting	☐	☐
ENDOCRINE:		
Cold or heat intolerance	☐	☐
Increased thirst	☐	☐
Increased urine	☐	☐
Increased hunger	☐	☐
GENITOURINARY:		
Difficulty urinating	☐	☐
Painful urination	☐	☐
Bladder control issues	☐	☐
Stomach pain	☐	☐
Frequency	☐	☐
Genital sore	☐	☐
Blood in urine	☐	☐
Penile discharge	☐	☐
Penile pain	☐	☐
Penile swelling	☐	☐
Scrotal swelling	☐	☐
Testicular pain	☐	☐
Urgency	☐	☐
Urine decreased	☐	☐
MUSCLE:		
Arthritis	☐	☐
Back pain	☐	☐
Gait problem	☐	☐
Joint swelling or pain	☐	☐
Muscle pain	☐	☐
Neck pain/stiffness	☐	☐

SKIN:	NO	YES
Color change	☐	☐
Pallor	☐	☐
Rash	☐	☐
Wound	☐	☐
ALLERGIC/IMMUNO:		
Env. allergies	☐	☐
Food allergies	☐	☐
Immunocompromised	☐	☐
NEUROLOGICAL:		
Dizziness	☐	☐
Facial asymmetry	☐	☐
Headaches	☐	☐
Light-headedness	☐	☐
Numbness	☐	☐
Seizures	☐	☐
Speech difficulty	☐	☐
Fainting	☐	☐
Tremors	☐	☐
Weakness	☐	☐
HEMOTOLOGIC and LYMPHATIC:		
Swollen lymph nodes	☐	☐
Bruises/bleeds easily	☐	☐
PSYCHIATRIC:		
Agitation	☐	☐
Behavior problem	☐	☐
Confusion	☐	☐
Decreased concentration	☐	☐
Uneasy mood	☐	☐
Hallucinations	☐	☐
Hyperactive	☐	☐
Nervous/anxious	☐	☐
Self-injury	☐	☐
Sleep disturbance	☐	☐
Suicidal	☐	☐

Physician Signature: ______________________________ Date: ____________ Time: ____________