Mark P. Crick, M.D.
Internal Medicine

PATIENT QUESTIONNAIRE

NAME: _____ DATE: _____

DATE OF BIRTH: _____

Medical History

Please CIRCLE any of the following that you, personally, have been diagnosed with, either now or in the past.

1. Diabetes
2. High Cholesterol
3. High Blood Pressure
4. Heart Disease
5. Strokes
6. Arthritis
7. Cancer
8. Thyroid Disease
9. Psychiatric Problems
10. Anemia
11. Glaucoma
12. Asthma or Lung Problems
13. Previous Blood Transfusions
14. Exposure or History of TB
15. Kidney Problems
16. Gout
17. History of Hepatitis
18. Sexually Transmitted Disease
19. Anxiety or Depression

19. Other: _____

Surgical History

Please CIRCLE any operations you have had. Write the YEAR it occurred.

1. Appendectomy _____
2. Back surgery _____
3. Breast biopsy _____
4. Breast implants _____
5. Cataract surgery _____
6. Foot surgery _____
7. Gallbladder surgery _____
8. Heart surgery _____
10. Hysterectomy (0 or 1 ovary) _____
11. Hysterectomy (both ovaries) _____
12. Knee surgery _____
13. Thyroid surgery _____
14. Tonsillectomy _____
15. Tubes tied _____
16. Vasectomy _____
17. Sinus surgery _____
18. Hernia repair _____

19. Other _____

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Preventive Medical History

Date of Last Sigmoidoscopy (tube looking for colon cancer) colonoscopy or _____

Date of Last Mammogram _____

Date of Last PAP Smear _____

Date of Last Tetanus Vaccination _____

Date of Pneumonia Vaccination _____

Did you have Flu Vaccination this year? YES NO

Do you (women) perform monthly breast self-examinations? YES NO

Do you (men under 40 years old) perform monthly testicular self-examinations? YES NO

Family History

Is your Mother Alive? YES NO Age or Age Deceased _____ Cause of Death _____

Is your Father Alive? YES NO Age or Age Deceased _____ Cause of Death _____

1. Who in your family has / had High Blood Pressure (please circle)?
   MOTHER FATHER BROTHERS or SISTERS GRANDPARENTS

2. Who in your family has / had Diabetes (please circle)?
   MOTHER FATHER BROTHERS or SISTERS GRANDPARENTS

3 Who in your family has / had Stroke (please circle)?
   MOTHER FATHER BROTHERS or SISTERS GRANDPARENTS

4. Who in your family has / had Melanoma (a serious skin cancer - please circle)?
   MOTHER FATHER BROTHERS or SISTERS GRANDPARENTS

5. Who in your family has / had Heart Disease (please circle)?
   MOTHER FATHER BROTHERS or SISTERS GRANDPARENTS

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Family History (continued)

6. Who in your family has / had Colon Cancer (intestinal cancer - please circle)?
   MOTHER FATHER BROTHERS or SISTERS GRANDPARENTS

7. Who in your family has / had Breast Cancer? Mother Sisters Grandmother
   How old when discovered? _____ _____ _____

8. Who in your family has / had Ovarian Cancer? Mother Sisters Grandmother

9. Who in your family has / had Prostate Cancer? Father Brothers Grandfather
   How old when discovered? _____ _____ _____

10. What other diseases run in your family? _____

Lifestyle History

Please CIRCLE the appropriate answer:

How much alcohol do you drink?

NONE RARELY OCCASIONALLY WEEKENDS ONLY 1 - 3 / WEEK 1 - 2 / DAY 2 - 3 / DAY MORE THAN 3 / DAY

Do you smoke cigarettes? NEVER STILL SMOKING QUIT SMOKING—when? _____
(month and year quit)

How much on average did / do you smoke a day?

OCCASIONALLY 1/2 PACK A DAY 1 PACK 1 - 2 PACKS 2 PACKS MORE THAN 2 PACKS

How many caffeinated drinks do you drink? Count coffee, tea, colas. Don't count *de-caffeinated.*

NONE 1-2 CUPS A DAY 3 - 4 CUPS PER DAY 5 - 6 CUPS PER DAY MORE THAN 6 CUPS PER DAY

How much planned aerobic exercise? 20 minutes or more (walking, jogging, bicycling, etc.)

NONE SPORADICALLY 1 - 2 TIMES A WEEK 3 - 4 TIMES A WEEK 5 - 6 TIMES A WEEK

Thank you for providing this information and allowing us to assist you with your health care needs.

Mark P. Crick, M.D.