

Baptist Physician Network
Pre-evaluation Patient Questionnaire

Name: _____ Date of Birth: _____

Reason for your visit today: _____

How long has this been a problem: _____

Have you been treated for this problem by another provider in the past? () Yes () No

If so, who treated you and what was done? _____

Please note any other conditions for which you see a doctor:

_____ High Blood Pressure	_____ Kidney Disease	_____ Heart Disease
_____ Diabetes	_____ Dialysis	_____ Heart Valve Disease
_____ Stroke	_____ Blood Clot/DVT	_____ History of Blood Thinners
_____ High Cholesterol	_____ Seizures	_____ Crohns Disease
_____ Liver Disease	_____ HIV/ AIDS	_____ Stent Placement (Cardiac or other)
_____ Acid Reflux	_____ Heart Rhythm	
_____ Asthma	_____ Thyroid (Hyper/Hypo)	
_____ Ulcerative Colitis	_____ COPD	
_____ History of Cancer?	If yes, where: _____	

Please list any other conditions: _____

Gynecologic History: Number of pregnancies _____ Age when first child born _____
Method of delivery () Natural () C-Section
Date of last menstrual period or age of menopause _____
Age of menarche (starting cycle) _____

List all prior surgical procedures and hospitalizations with approximate dates: _____

Do you take blood thinners? (Aspirin, Plavix, Coumadin/Warfarin) () Yes () No

Current Medications (please list all prescribed, herbal and over the counter medications along with dosage): _____

Allergies: _____

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Social History

Are you currently employed? () Yes () No if so, what is your occupation(s)? _____
if disabled, please list the nature of your disability _____

Do you use tobacco products? () Yes () No if yes, number of packs per day _____
number of years _____

Do you drink regularly? () Yes () No if yes, please list amount: _____

Do you use illicit drugs? () Yes () No if yes, please list: _____

Marital Status: _____ Single _____ Married _____ Widowed _____ Divorced

Please list any major illnesses or causes of death in your family members:

Mother: _____

Father: _____

M Grandparents: _____

P Grandparents: _____

Brothers: _____

Sisters: _____

Review of Symptoms: (Please circle any symptoms you are currently experiencing)

General: Anorexia, chills, fatigue, weight loss/amount _____

Ophthalmologic: Blurred vision, diminished visual acuity, eye pain

HEENT: Headache, decreased hearing, difficulty swallowing, sinus congestion,
sore throat, swollen glands

Endocrine: Cold intolerance, excessive thirst, heat intolerance

Respiratory: Cough, shortness of breath at rest, shortness of breath with exertion

Cardiovascular: Heartburn, chest pain/pressure, edema, palpitations, weakness

Gastrointestinal: Dark/tarry stools, incontinence, abdominal pain, blood in stool,
constipation, diarrhea, difficulty swallowing, nausea, vomiting

Women Only: Irregular menses, vaginal discharge/itching

Genitourinary: Blood in urine, difficulty urinating, frequent urination, painful urination

Musculoskeletal: Arthritis, painful joints, swollen joints, muscle weakness

Skin: Easy bleeding, jaundice, easy bruising, dry skin, rash

Neurologic: Dizziness, fainting, headache, seizures, tingling/numbness

Psychiatric: Bipolar disorder, mania, anxiety, depressed mood, suicidal thoughts