

**SUMMIT MEDICAL GROUP**  
**Health Information Questionnaire**

**Today's Date:** \_\_\_\_\_ **Which doctor are you seeing today?** \_\_\_\_\_  
**Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Pharmacy Name:** \_\_\_\_\_ **Telephone Number:** \_\_\_\_\_  
**What medications are you currently taking?**

Medication:	Prescribed by:	Do you need a refill today?

Are you allergic to any medications? \_\_\_\_\_ If yes, what medication? \_\_\_\_\_  
 What type of reaction did you have to this medication? \_\_\_\_\_  
 Are you currently pregnant or nursing? \_\_\_\_\_  
 What is the reason for your visit today? \_\_\_\_\_

**Please check any symptoms below that you are currently experiencing:**

- ◆ **General**
  - \_\_\_ Recent Weight gain/loss?  
Amount \_\_\_\_\_
  - \_\_\_ Fatigue/Lack of energy
  - \_\_\_ Fever/Night sweats
- ◆ **Ears/Eyes/Nose**
  - \_\_\_ Ringing in ears or hearing loss
  - \_\_\_ Loss of vision
  - \_\_\_ Double or blurred vision
  - \_\_\_ Sinus drainage or congestion
- ◆ **Mouth/Throat**
  - \_\_\_ Sores in mouth
  - \_\_\_ Hoarseness
  - \_\_\_ Difficulty or painful swallowing
  - \_\_\_ Swollen glands
- ◆ **Breasts**
  - \_\_\_ Pain
  - \_\_\_ Lump
  - \_\_\_ Discharge from Nipple
- ◆ **Heart and Lungs**
  - \_\_\_ Pain in chest
  - \_\_\_ Irregular/Fluttering heart beat
  - \_\_\_ Shortness of breath
  - \_\_\_ Short of breath when lying flat
  - \_\_\_ Swollen legs/feet
  - \_\_\_ Cough
  - \_\_\_ Coughing of Blood
  - \_\_\_ Wheezing
- ◆ **Stomach/Intestines**
  - \_\_\_ Frequent heartburn
  - \_\_\_ Nausea
  - \_\_\_ Vomiting of Blood
  - \_\_\_ Constipation
  - \_\_\_ Persistent Diarrhea
  - \_\_\_ Red blood in stools
  - \_\_\_ Black or tarry stools
- ◆ **Kidneys/Bladder**
  - \_\_\_ Painful urination
  - \_\_\_ Discharge from penis/vagina
  - \_\_\_ Blood in Urine
  - \_\_\_ Getting up at night to urinate  
How many times? \_\_\_\_\_
- ◆ **Skin**
  - \_\_\_ Rash
  - \_\_\_ Sores/Moles that won't heal
  - \_\_\_ Dark or enlarging moles
- ◆ **Muscles/Joints/Bones**
  - \_\_\_ Morning stiffness  
Minutes \_\_\_\_\_  
Hours \_\_\_\_\_
  - \_\_\_ Joint pain or swelling  
Where? \_\_\_\_\_
  - \_\_\_ Muscle weakness/Tenderness
- ◆ **Nervous System**
  - \_\_\_ Frequent headaches
  - \_\_\_ Sensitivity to pain in hands or feet
- \_\_\_ Memory loss
- \_\_\_ Difficulty walking or with balance/coordination
- ◆ **Endocrine**
  - \_\_\_ Heat or cold intolerance
  - \_\_\_ Excessive thirst/urination
  - \_\_\_ Periods regular  
Yes \_\_\_\_\_ No \_\_\_\_\_
  - Last Menstrual Period: \_\_\_\_\_
  - Age when periods stopped \_\_\_\_\_
  - Last Pap: \_\_\_\_\_
  - Contraception: \_\_\_\_\_
- ◆ **Habits**
  - Do you use tobacco products?  
Yes \_\_\_\_\_ No \_\_\_\_\_ Past \_\_\_\_\_
  - Cigarettes per day \_\_\_\_\_
  - How many years have or did you use tobacco? \_\_\_\_\_
  - Drink more than 2 alcoholic beverages per day?  
Yes \_\_\_\_\_ No \_\_\_\_\_
  - Cups of coffee per day? \_\_\_\_\_
  - Use seatbelt regularly?  
Yes \_\_\_\_\_ No \_\_\_\_\_
  - Do you use drugs for reasons that are not medical? If so, please list:  
\_\_\_\_\_  
\_\_\_\_\_

**(See additional questions on back of form.)**

**Past History:**

Have you been treated for any of the following conditions in the past? If so, please list approximate dates of treatment and treating physician.

Condition:	Approximate Dates of Treatment:	Treating Physician:
Psychological:		
Diabetes		
GI Disease		
Liver Disease		
Heart Disease		
Phlebitis		
Anemia		
Arthritis		
Blood Disease		
Thyroid Disease		
Weight		
Cholesterol		
Seizures		
High blood pressure		
Stroke		
Genital/Urinary Disease		
Serious Accident:		
Surgeries:		
Hospitalizations:		

Marital Status: \_\_\_\_\_ Number of Children: \_\_\_\_\_

**Family History:**

Have any members of your immediate family (parents, siblings, grandparents, children) ever had:

- Breast Cancer? \_\_\_\_\_ If so, whom? \_\_\_\_\_
- Colon Cancer? \_\_\_\_\_ If so, whom? \_\_\_\_\_
- Other types of cancer? \_\_\_\_\_ If so, whom? \_\_\_\_\_
- High blood pressure? \_\_\_\_\_ If so, whom? \_\_\_\_\_
- Stroke? \_\_\_\_\_ If so, whom? \_\_\_\_\_
- Heart problems? \_\_\_\_\_ If so, whom? \_\_\_\_\_
- Diabetes? \_\_\_\_\_ If so, whom? \_\_\_\_\_

Please list any other relevant information or questions you may have for the physician today:

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