Diagnostic Clinic of Houston
MODERN MEDICINE • SENSITIVE CARE

Locations
□ Museum District □ Medical Center
□ W. Houston □ Katy □ Pearland □ Pasadena
www.diagnosticclinic.com

Patient Questionnaire

Date_____ **Patient Status**: □ New □ Established □ Consultation □ Referral Date of Birth_____

Patient Name (Last)_____ (First)_____ (MI)_____ Sex_____

What is the principle reason for your visit?_____
What are your symptoms/complaints?_____
When did your symptoms start?_____
What treatments have you tried?_____

Review of Systems:

Please check all CURRENT symptoms/complaints.

General
□ Fatigue
□ Weakness
□ Fever
□ Chills
□ Night Sweats
□ Poor Appetite
□ Weight Loss lbs._____
□ Weight Gain lbs._____

Eyes
□ Glasses/Contact
□ Blurred
□ Decreased
□ Doubled
□ Color Blindness
□ Pain
□ Discharge
□ Redness
□ Dry
□ Teary

Ear/Nose/Throat
□ Ear Pain
□ Hearing Loss
□ Ear Discharge
□ Ringing in Ears
□ Sensitive to Sound
□ Nasal Congestion
□ Runny Nose
□ Nose Bleeds
□ Ulcers
□ Sinus Problems
□ Sore throat
□ Hoarseness
□ Mouth Sores
□ Tongue Sores
□ Tooth Problems
□ Gum Problems

Cardiovascular
□ Chest Pain
□ Palpitations
□ Heart Murmur
□ Poor Circulation
□ Feet/Ankle Swelling
□ Varicose Veins

Respiratory
□ Cough
□ Coughing Blood
□ Excess Phlegm
□ Shortness of Breath
□ Wheezing
□ Exposure to Tuberculosis

Gastrointestinal
□ Abdominal Pain
□ Abdominal Bloating
□ Nausea
□ Vomiting
□ Diarrhea
□ Constipation
□ Bloody Stool
□ Black/Tarry Stool
□ Excessive Gas
□ Rectal Bleeding
□ Hemorrhoids
□ Acid Reflux
□ Heartburn
□ Trouble Swallowing

Genitourinary
□ Frequent Urination
□ Frequent Urination at Night
□ Incontinence
□ Urinary Retention
□ Painful Urination
□ Urine Stream Change
□ Blood in Urine
□ Dark Urine
□ Frequent UTIs
□ Genital Lesions
□ High Risk Sexual Behavior

Musculoskeletal
□ Joint Pain
□ Joint Swelling
□ Joint Stiffness
□ Achy Muscles
□ Weak Muscles
□ Bone Pain
□ Back Pain
□ Leg Cramps

Endocrine
□ Heat Intolerance
□ Cold Intolerance
□ Excess Sweating
□ Abnormal Skin Pigment
□ Excess Hunger
□ Excess Thirst

Hema / Lymph
□ Easy Bruising
□ Excessive Bleeding
□ Blood Clots
□ Swollen Lymph Nodes
Where?_____
_____
_____

Dermatologic
□ Acne
□ Mole Changes
□ Excessive Dry Skin
□ Clammy Skin
□ Fungal Nail Infections
□ Jaundice
□ Itching
□ Rash
□ Warts
□ Hives
□ Sore/Ulcers
□ Bruising
□ Scaling
□ Skin Thickening
□ Hair Loss
□ Abnormal Hair Growth
□ Dry/Brittle Hair

Neurological
□ Seizures
□ Tremors
□ Weakness
□ Headaches
□ Migraines
□ Numbness
□ Dizziness
□ Loss of Balance
□ Fainting
□ Speech Problems
□ Memory Loss
□ Black Outs
□ Confusion

Psychiatric
□ Anxiety
□ Depression
□ Stress
□ Panic Attacks
□ Mood Swings
□ Personality Change
□ Poor Concentration
□ Suicidal
□ Drug/Alcohol Use

Sleep
□ Insomnia
□ Excessively Sleepy
□ Sleep Disturbance
□ Snoring
□ Apnea
□ Sleep Walking
□ Sleep Talking
□ Night Terrors

Males
□ Impotence
□ Penile Discharge
□ Enlarged Breast
□ Nipple Discharge
□ Breast Lump(s)
□ Infertility
□ Loss of Sex Drive

Females
□ Vaginal Discharge
□ Vaginal Dryness
□ Breast Pain
□ Nipple Discharge
□ Breast Lump(s)
□ Irregular Periods
□ Painful Periods
□ Heavy Periods
□ Infertility
□ Hot Flashes
□ Loss of Sex Drive

Allergies
_____
_____
_____
_____

Medications:

Please be certain to include birth control, hormones, and ALL non-prescription medications

Medication	Dosage	Medication	Dosage

Preferred Pharmacy_____ Phone_____
Address_____ City _____ State _____ Zip _____

_____ _____
Signature of Patient or Guardian **Date**

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Past Medical History:

Date of Last Physical?_____ Abnormalities? □ No □ Yes Explain_____

Gastrointestinal
□ NONE
□ Heartburn
□ Reflux Symptoms
□ Gallstones
□ Ulcerative Colitis
□ Anal Fistula
□ Hiatal Hernia
□ Pancreatitis
□ Crohn's Disease
□ Stool Incontinence
□ Gastritis
□ Irritable Bowel (185)
□ Colon Polyps
□ Abnormal Liver Tests
□ H. Pylori
□ Spastic Colitis
□ Colon Cancer
□ Fatty Liver
□ Ulcer
□ Lactose Intolerance
□ Hemorrhoids
□ Hepatitis
□ Celiac Disease
□ Diverticulosis
□ Diverticulitis
□ Anal Fissure
□ Cirrhosis

Cardiovascular
□ NONE
□ High Blood Pressure
□ Heart Attack
□ PVCs
□ Mitrai Valve Prolapse
□ High Cholesterol
□ Atrial Fibrillation
□ Rhythm Disorder
□ Rheumatic Fever
□ Angina
□ Tachycardia
□ Heart Murmur
□ Congestive Heart Failure

Pulmonary
□ NONE
□ Sleep Apnea
□ Emphysema (COPD)
□ Pulmonary Embolism
□ Lung Cancer
□ Asthma
□ Pneumonia
□ Sarcoidosis
□ Pleurisy

Neuropsychiatric
□ NONE
□ Stroke
□ Migraines
□ Dementia
□ Alzheimer's
□ Eating Disorder
□ TIA (Mini Stroke)
□ Chronic Headaches
□ Depression
□ ADHD
□ Multiple Sclerosis
□ Parkinson's Disease
□ Anxiety Hormonal Mood
□ Seizures
□ Myasthenia Gravis
□ Bipolar Disorder
□ Panic Disorder

Hematologic
□ NONE
□ Anemia
□ Blood Clot(s)
□ Hodgkin's Disease
□ Leukemia
□ Blood Transfusion
□ Hemochromatosis
□ Lymphoma
□ Myelodysplasia

Endocrine
□ NONE
□ Diabetes
□ Hyperthyroidism
□ Goiter
□ Pituitary Problem
□ Hypothyroidism
□ Thyroid Nodule
□ Thyroid Cancer
□ Adrenal Problem

Genitourinary
□ NONE
□ Kidney Disease
□ Urinary Tract Infections
□ Ovarian Cyst(s)
□ Kidney Stones
□ Bladder Incontinence
□ Ovarian Cancer
□ Cone Biopsy/Leep
□ Kidney Tumors
□ Kidney Cysts
□ Kidney Cancer
□ Prostate Hypertrophy
□ Uterine Fibroids
□ Cervical Cancer
□ Bladder Cancer
□ Prostate Cancer
□ Uterine Cancer
□ Endometriosis

Breast
□ NONE
□ Fibrocystic Breast Disease
□ Breast Cancer (L or R)
□ Radiation
□ Chemotherapy

Musculoskeletal
□ NONE
□ Osteoarthritis
□ Osteoporosis
□ Fibromyalgia
□ Lupus
□ Rheumatoid Arthritis
□ Osteopenia
□ Polymyalgia Rheumatic
□ Gout

Eyes, Ears, Nose & Throat
□ NONE
□ Glaucoma
□ Macular Degeneration
□ Allergic Rhinitis
□ Oral Thrush
□ Cataracts
□ Retinal Detachment
□ Sinusitis
□ Sjogren's (Dry Eyes)

Dermatologic
□ NONE
□ Eczema
□ Vitiligo
□ Raynaud's Syndrome
□ Squamous Cell Skin Cancer
□ Psoriasis
□ Alopecia
□ Basal Cell Skin Cancer
□ Melanoma
□ Scleroderm

Oncologic
□ NONE
□ Any other malignant tumors not previously mentioned_____
_____
_____

Infectious Disease
□ NONE
□ Tuberculosis
□ Hepatitis
□ Gonorrhea
□ Syphilis
□ HIV
□ Other_____
_____
_____

Any other medical conditions not previously mentioned?_____

Females Menopaused? □ No □ Yes Age_____ Form of Birth Control?_____

Age at First Period_____ Date of Last Period_____ Every_____ Days, For_____ Days_____

Pregnancies_____ Miscarriages/Abortions_____Living Children_____ Full Term Births_Premature Births_____

Date of Last Pap?_____ Abnormalities? □ No □ Yes Explain_____

Date of Last Breast Exam?_____ Abnormalities? □ No □ Yes Explain_____

Past Surgeries / Procedures / Treatments

□ NONE
□ Gallbladder
□ Colonoscopy
□ D & C
□ Vasectomy
□ Back Surgery
□ Appendix
□ C-Section
□ Prostate Surgery
□ Foot Surgery
□ Groin Hernia Repair
□ Tubal Ligation
□ Tonsillectomy
□ Stent/Angioplasty
□ Other Hernia Repair
□ Total Hysterectomy
□ Sinus Surgery
□ Heart Bypass Surgery
□ Bowel Obstruction
□ Partial Hysterectomy
□ Cataract Surgery
□ Heart Valve Surgery
□ Adhesion Surgery
□ Ovarian Surgery
□ Lasik Eye Surgery
□ Pacemaker
□ Colon Resection
□ Uterine Ablation
□ Pacemaker
□ Other Eye Surgery
□ Defibrillator
□ Hemorrhoid Surgery
□ Benign Breast Biopsy
□ Arthroscopy
□ Carotid Surgery
□ Vein Stripping
□ Anti-Reflux Surgery
□ Kidney Transplant
□ Fistula
□ Catheter
□ Lumpectomy
□ Knee Replacement
□ Vascular Surgery
□ Weight Loss Surgery
□ Mastectomy
□ Hip Replacement

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□ Other surgeries not previously mentioned? _____

Family History:

□ NONE □ Colon Polyps □ Crohn's Disease □ Helicobacter Pylori □ Colon/Rectal Cancer □ Stomach Cancer
□ Hepatitis C □ Hepatitis B □ Uterine Cancer □ Celiac Disease □ Hemochromatosis □ Ulcerative Colitis
□ Other

If yes, list family members (i.e. mother, grandmother, sister, aunt) and age at diagnosis of polyps or cancers:

_____
_____
_____

Father: Living? □ No □ Yes Age_____ Health_____
Dead? □ No □ Yes At Age_____ Cause of Death_____

Mother: Living? □ No □ Yes Age_____ Health_____
Dead? □ No □ Yes At Age_____ Cause of Death_____

Brothers? □ No □ Yes No. Living_____ Age(s)_____ Health_____
No. Dead_____ At Age(s)_____ Cause of Death_____

Sisters? □ No □ Yes No. Living_____ Age(s)_____ Health_____
No. Dead_____ At Age(s)_____ Cause of Death_____

Children? □ No □ Yes No. Living_____ Age(s)_____ Health_____
No. Dead_____ At Age(s)_____ Cause of Death_____

Social History:

Marital Status □ Single/Never Been Married
□ Married How Long_____ Spouse Age_____ Health_____
□ Separated How Long_____
□ Divorced How Long_____
□ Widowed How Long_____ Died At Age_____ Cause of Death_____

Tobacco Use □ Never □ Ex-User When quit?_____ □ Current Amount per day?_____ How Long?_____

Alcohol Use □ Never □ Occasional □ Social □ Frequent Amount per day?_____ How Long?_____

Problems with Alcohol or Drug use? □ No □ Yes Explain_____

Drink Caffeinated Beverages □ No □ Yes Number of cups per day of: ____Coffee ____Tea ____Soda

Currently Dieting □ No □ Yes How Long?_____ Explain_____

Occupation (Or most recent job held)_____

Do you work unusually hard or long hours? □ No □ Yes Explain_____

Is there a lot of tension or pressure in your job? □ No □ Yes Explain_____

Does your job cause you to stress frequently? □ No □ Yes Explain_____

Do you enjoy your job? □ No □ Yes Explain_____

Other Is there any other information that is pertinent about your medical history?_____
_____
_____
_____

_____ _____
Signature of Patient or Guardian **Date**