

**PATIENT INFORMATION**

Patient's Name \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: \_\_\_\_\_

What will we be seeing you for?

**INSURANCE**

Primary Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Patient's Relationship to Insured: \_\_\_\_\_

Primary Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Patient's Relationship to Insured: \_\_\_\_\_

## PATIENT QUESTIONNAIRE

The information requested in this questionnaire is very important. To give you the best care and to obtain insurance approval if applicable, please fill out as completely as possible.

In your own words, please describe your condition, how it affects your life, what makes any symptoms worse or better, and what testing was performed:

Your Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

### PAST MEDICAL HISTORY

- Check here if you have no active or past medical history issues
- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Swollen Legs  | <input type="checkbox"/> Emphysema                |
| <input type="checkbox"/> Acid Reflux         | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Prostate Cancer          |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sleep Apnea   | <input type="checkbox"/> Colon Cancer             |
| <input type="checkbox"/> Chronic Bronchitis  | <input type="checkbox"/> Asthma        | <input type="checkbox"/> Ovarian Cancer           |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Congestive Heart Failure |

Additional Information or other conditions not listed above: \_\_\_\_\_

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### SURGICAL HISTORY

- Check here if you have no previous surgeries or hospitalizations
- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Tonsillectomy                            | <input type="checkbox"/> Ovaries Removed  | <input type="checkbox"/> Hernia Repair     |
| <input type="checkbox"/> Appendectomy                             | <input type="checkbox"/> Cesarean Section | <input type="checkbox"/> Organ Transplant  |
| <input type="checkbox"/> Hysterectomy                             | <input type="checkbox"/> Spinal Fusion    | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Spleen Removed                           | <input type="checkbox"/> Gallbladder      |  |
| <input type="checkbox"/> Part of colon or small intestine removed |   |  |

Additional Information or other surgeries not listed above: \_\_\_\_\_

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## **FAMILY HISTORY**

- |  |                                   |
|--|-----------------------------------|
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Obesity  |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Other    |

## **SOCIAL HISTORY**

Alcohol Consumption: \_\_\_\_\_ If yes, explain quantity and frequency: \_\_\_\_\_

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Tobacco Consumption: \_\_\_\_\_ If yes, explain quantity and frequency: \_\_\_\_\_

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Recreational Drugs: \_\_\_\_\_ If yes, explain what and frequency: \_\_\_\_\_

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Occupation: \_\_\_\_\_

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Please note any quitting history to the above listed: \_\_\_\_\_

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Please check any item or area that has been or is a concern to you or is a medical/health issue which you have dealt with:

## **GENERAL**

- |  |                                  |
|--|----------------------------------|
| <input type="checkbox"/> Weight Loss or Gain | <input type="checkbox"/> Fever   |
| <input type="checkbox"/> Loss of Appetite    | <input type="checkbox"/> Fatigue |

## **SKIN/BREAST**

- |  |                                       |  |
|--|---------------------------------------|--|
| <input type="checkbox"/> Rash              | <input type="checkbox"/> Itching      | <input type="checkbox"/> Breast Lump     |
| <input type="checkbox"/> Breast Tenderness | <input type="checkbox"/> Dry Skin     | <input type="checkbox"/> Breast Swelling |
| <input type="checkbox"/> Nipple Discharge  | <input type="checkbox"/> Pigmentation |  |

## EARS/EYES/NOSE/MOUTH/THROAT

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Headaches       | <input type="checkbox"/> Dizziness     | <input type="checkbox"/> Light Headedness                       |
| <input type="checkbox"/> Tearing         | <input type="checkbox"/> Head Injury   | <input type="checkbox"/> Vision Change                          |
| <input type="checkbox"/> Double Vision   | <input type="checkbox"/> Eye Pain      | <input type="checkbox"/> Nose Bleeding                          |
| <input type="checkbox"/> Hoarse Voice    | <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Sinus Infection                        |
| <input type="checkbox"/> Trouble Hearing | <input type="checkbox"/> Thyroid Mass  | <input type="checkbox"/> Neck Stiffness, Pain,<br>or Tenderness |

## CARDIOVASCULAR

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Chest Pain                              | <input type="checkbox"/> Palpitations  | <input type="checkbox"/> Short of breath<br>during exertion                 |
| <input type="checkbox"/> Fainting                                | <input type="checkbox"/> Swelling      | <input type="checkbox"/> Awakening at night<br>with difficulty<br>breathing |
| <input type="checkbox"/> Difficulty breathing<br>when lying down | <input type="checkbox"/> Heart Murmurs |   |

## RESPIRATORY

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Pain with Breathing | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Wheezing             |
| <input type="checkbox"/> Cough               | <input type="checkbox"/> Coughing Up Blood   | <input type="checkbox"/> Recurring Infections |
| <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Night Sweats        |   |

## GASTROINTESTINAL

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Loss of Appetite    | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Stomach ache after<br>eating |
| <input type="checkbox"/> Nausea and Vomiting | <input type="checkbox"/> Vomiting Blood        | <input type="checkbox"/> Diarrhea                     |
| <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Heartburn             | <input type="checkbox"/> Constipation                 |
| <input type="checkbox"/> Abnormal Stools     | <input type="checkbox"/> Hemorrhoids           |   |

## GENITOURINARY

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Urgency              | <input type="checkbox"/> Frequency         | <input type="checkbox"/> Pain with Urination |
| <input type="checkbox"/> Blood in Urine       | <input type="checkbox"/> Excessive Urine   | <input type="checkbox"/> Urinary Retention   |
| <input type="checkbox"/> Recurring Infections | <input type="checkbox"/> Kidney Stones     | <input type="checkbox"/> Vaginal Discharge   |
| <input type="checkbox"/> Vaginal Bleeding     | <input type="checkbox"/> Enlarged Prostate |  |

## NEUROLOGIC/PSYCHIATRIC

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Seizures          | <input type="checkbox"/> Paralysis         | <input type="checkbox"/> Incoordination                |
| <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Loss of Memory    | <input type="checkbox"/> Uncoordinated Movements       |
| <input type="checkbox"/> Tremor            | <input type="checkbox"/> Depression        | <input type="checkbox"/> Sensory or Motor Disturbances |
| <input type="checkbox"/> Hallucinations    | <input type="checkbox"/> Suicidal Thoughts |  |
| <input type="checkbox"/> Anxiety           |  |  |

## MUSCOLOSKELETAL

- |  |                                   |   |
|--|-----------------------------------|---|
| <input type="checkbox"/> Pain                    | <input type="checkbox"/> Swelling | <input type="checkbox"/> Night Cramps   |
| <input type="checkbox"/> Joint Pain              | <input type="checkbox"/> Weakness | <input type="checkbox"/> Muscle Atrophy |
| <input type="checkbox"/> Limited Range of Motion |                                   |   |

## VASCULAR

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Mini Strokes           | <input type="checkbox"/> Shortness of Breath   | <input type="checkbox"/> Leg cramps when walking |
| <input type="checkbox"/> Temporary Vision Loss  | <input type="checkbox"/> Strokes               | <input type="checkbox"/> Weak or numb one side   |
| <input type="checkbox"/> Difficulty Speaking    | <input type="checkbox"/> Non-Healing foot sore |  |
| <input type="checkbox"/> Pain in calves at rest |  |  |

## ALLERGIC/IMMUNOLOGIC/LYMPHATIC/ENDOCRINE

- |  |                                       |   |
|--|---------------------------------------|---|
| <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Transfusions | <input type="checkbox"/> Heat or cold intolerance |
| <input type="checkbox"/> Anemia            |                                       |   |

## ALLERGIES

Type in any allergies to medications you have: \_\_\_\_\_

\_\_\_\_\_

## MEDICATIONS

Type in any medications you are currently taking: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## DIETARY HISTORY

Approximate age when you first seriously dieted: \_\_\_\_\_

List the diets and diet programs you have tried:

Program	Date	Duration	Supervised	Max Loss/Regained
<input type="checkbox"/> Jenny Craig	_____	_____	<input type="checkbox"/> Yes	_____
<input type="checkbox"/> Nurti-System	_____	_____	<input type="checkbox"/> Yes	_____
<input type="checkbox"/> Weight Watchers	_____	_____	<input type="checkbox"/> Yes	_____
<input type="checkbox"/> Optifast	_____	_____	<input type="checkbox"/> Yes	_____
<input type="checkbox"/> Medifast	_____	_____	<input type="checkbox"/> Yes	_____
<input type="checkbox"/> LA Weight Loss	_____	_____	<input type="checkbox"/> Yes	_____
<input type="checkbox"/> Fen/Phen/Redux	_____	_____	<input type="checkbox"/> Yes	_____
<input type="checkbox"/> Meridia	_____	_____	<input type="checkbox"/> Yes	_____
<input type="checkbox"/> Lindora	_____	_____	<input type="checkbox"/> Yes	_____
<input type="checkbox"/> T.O.P.S	_____	_____	<input type="checkbox"/> Yes	_____
<input type="checkbox"/> Overeaters Anon	_____	_____	<input type="checkbox"/> Yes	_____
<input type="checkbox"/> Accupuncture	_____	_____	<input type="checkbox"/> Yes	_____
<input type="checkbox"/> Metabolife	_____	_____	<input type="checkbox"/> Yes	_____
<input type="checkbox"/> Atkins Diet	_____	_____	<input type="checkbox"/> Yes	_____

List any other physician-supervised, self-directed exercising and/or documented weight loss attempts: \_\_\_\_\_

Your current height: \_\_\_\_\_ Your current weight: \_\_\_\_\_

Your lowest point in past 5 years: \_\_\_\_\_ Age at the time: \_\_\_\_\_

Highest weight in past 5 years: \_\_\_\_\_ Age at the time: \_\_\_\_\_

Thank you for making the time to review your medical and health history.

Sincerely,



Dr. Darrin F. Hansen, MD