MP VEERA MD PA

INTERNAL MEDICINE QUESTIONNAIRE

PATIENT
NAME_____DOB_____MALE/FEMALE
ALLERGIES_____
_____
REASON FOR OFFICE VISIT_____

CHECK IF YOU HAVE HISTORY OF:

BLOATING/GAS___
RECENT WEIGHT LOSS/GAIN___
FATIGUE/TIREDNESS___
RECTAL BLEED___
SWALLOWING PROBLEMS___
BOWEL PROBLEMS___
ABDOMINAL PROBLEMS___
STOMACH PROBLEMS___
NAUSEA/VOMITING___
CHEST PAIN___
DIARRHEA/CONSTIPATION___
ANXIETY/DEPRESSION___
ITCHING/SKIN RASH___
NUMBNESS___
HEADACHES/MIGRAINE___
SWOLLEN GLANDS___
HEAT COLD BOTHER YOU___
SHORTNESS OF BREATH___
HEARING LOSS___
EASY BRUISING___

ALCOHOLISM___
ANEMIA___
ANGINA___
ARTHRITIS___
ASTHMA___
BLADDER INFECTIONS___
BROKEN BONES___
CANCER___
COLON CANCER___
COLON POLYPS___
COUGH/BLOOD IN SPUTUM___
DIABETES___
DIVERTICULOSIS___
LUNG DISEASE___
EPILEPSY/SEIZURE___
EYE DISEASE___
ESOPHAGEAL STRICTURES___
GALLBLADDER DISEASE___
GASTROPARESIS____
HEART ATTACK/DISEASE___

HEART MURMUR___
HEPATITIS___
HIATAL HERNIA___
HIGH BLOOD PRESSURE___
HIGH CHOLESTEROL___
HIV___
JAUNDICE___
KIDNEY DISEASE/STONE___
LIVER DISEASE___
OSTEOPOROSIS___
RHEUMATIC FEVER___
STROKE___
THYROID DISEASE___
TUMOR___
PANCREATITIS___
STOMACH/DUOD ULCERS___
OTHER_____
_____
_____

CHECK IF FAMILY HISTORY OF: CANCER/COLON CANCER____ COLON POLYPS____DIABETES____

GALLBLADDER DISEASE____HEART DISEASE____ HIGH BLOOD PRESSURE____ LIVER PROBLEMS___
ARTHRITIS____ASTHMA____EPILEPSY____KIDNEY DISEASE____OTHER_____
_____
_____

SURGICAL HISTORY: **DATE:** **LOCATION:**

_____
_____
_____
_____
_____

PERSONAL HISTORY:

SMOKE YES/NO PACKS PER DAY_____ HOW LONG_____ WHEN STOPPED_____
CAFFEINE YES/NO CUPS DAILY_____OTHER TYPES CAFFEINE_____
ALCOHOL YES/NO TYPE/AMOUNT_____WHEN STOPPED_____
DRUG ABUSE YES/NO TYPE/ AMOUNT_____WHEN STOPPED_____
MARRIED/SINGLE/ DIVORCED/WIDOWED #CHILDREN_____#GRANDCHILDREN_____
SLEEP PATTERNS_____EXERCISE ROUTINES_____

FEMALES ONLY :PREGNANT **YES NO** DATE LAST MENTRAL PERIOD_____DATE LAST PAP SMEAR_____DATE LAST BREAST EXAM_____DATE LAST MAMMOGRAM_____

PATIENT SIGNATURE_____DATE_____

PRACTITIONER SIGNATURE_____DATE_____
NURSING UPDATE/INITIALS_____UPDATE_____UPDATE_____

Jan 20, 2014