Date 1 Month January Year 2002

Suburban Surgical Associates, Inc.

Health Questionnare

Patient Name

Age

e-mail Address

Referring Physician

What Brings you to the doctor today?

How long have you had this problem?

Please check if any of the following apply to you:

- High Blood Pressure ☐
- Heart Attack ☐
- Hyperlipidemia ☐
- Stroke ☐
- Bleeding Disorder ☐
- Skin Disorder ☐
- Spots in front of eyes ☐
- Memory loss ☐
- Hearing difficulty ☐
- Recent weight loss/weight gain ☐
- Change in bowel habit ☐
- Discoloration of foot or legs ☐
- Leg swelling ☐
- Blood clots ☐
- Diabetes ☐
- Heart problems ☐
- Lung problems ☐
- Kidney problems ☐
- Headaches ☐
- Temporary blindness ☐
- Dizziness ☐
- Slurred speech ☐
- Distended veins in neck ☐
- Decline in appetite ☐
- Sores or ulcer on feet or legs ☐
- Pain, cramps while walking ☐
- Varicose veins ☐
- Other medical problems ☐

If yes to pain, cramps or tiredness in legs or thighs, please answer yes or no below:

Does it limit work/lifestyle? ○ Yes ○ No

State distance you can walk in blocks before you get these symptoms.

Does pain make you stop walking? ○ Yes ○ No

Does pain go away if you rest for a few minutes? ○ Yes ○ No

Operations (please list, Date/Type)

Women Only

Are you taking oral contraceptives? ○ Yes ○ No

Men Only

Do you have problems with impotence ? (difficulty in obtaining or sustaining an erection) ○ Yes ○ No

All patients please complete the following.

Do you smoke cigarettes? ○ Yes ○ No If quit, when?

Do you consume alcohol? ○ Yes ○ No Are you right or left handed?

Please list all medications you are currently taking (please include dosage & frequency)

Do you have allergies? ○ Yes ○ No

If yes, please list

Occupation. If retired, what was your occupation?

Family History

List health problems of your parents, brothers or sisters. Please include cause of death for any expired family member.

Is there anything else you think your doctor should know about your condition?