PATIENT QUESTIONNAIRE

Name: ___________________________ Date: ___________________________
Your phone numbers: Home: ___________________________ Cell: ___________________________
Emergency Contact Person: ___________________________ Phone number: ___________________________

I came to see Dr. Kelly/Bakhoudarian by: 
_____ Referral from another physician (name): ___________________________
_____ Referral from a friend or another patient (name): ___________________________
_____ My own research (explain): ___________________________
_____ Other: ___________________________

Prior to seeing Dr. Kelly/Bakhoudarian I went online and reviewed the website: ___Yes ___No

Why are you seeing Dr. Kelly/Bakhoudarian? ___________________________

What are your symptoms related to this problem?
1. ___________________________
2. ___________________________
3. ___________________________
4. ___________________________

Have you been diagnosed with other medical problems?

☐ High blood pressure ___________________________
☐ High cholesterol/Hyperlipidemia ___________________________
☐ Lung disease/Asthma ___________________________
☐ Gastro-intestinal problems ___________________________
☐ Depression ___________________________
☐ Seizures ___________________________
☐ Pituitary/Hormone disorders ___________________________
☐ Cancer – type? ___________________________
☐ Heart disease (heart attack) ___________________________
☐ Diabetes ___________________________
☐ Thyroid ___________________________
☐ Kidney Disease/dialysis ___________________________
☐ Alzheimer’s/Parkinson’s disease ___________________________
☐ Stroke ___________________________
☐ Brain tumor (benign or malignant) ___________________________
☐ Other issues ___________________________

Please list any past surgeries and the year performed:
1. ___________________________
2. ___________________________
3. ___________________________

Which doctors need a copy of today’s consultation note from Dr. Kelly/Bakhoudarian? Please provide phone and fax numbers.
1. ___________________________
2. ___________________________
3. ___________________________
4. ___________________________

MEDICATIONS

Are you taking any medications? Yes ☐ No ☐ If YES please list below:

1. ___________________________
2. ___________________________
3. ___________________________
4. ___________________________
5. ___________________________
6. ___________________________
7. ___________________________
8. ___________________________

ALLERGIES: Do you have any allergies to medications? Yes ☐ No ☐ If YES please list below and describe reaction to medication:

1. ___________________________
2. ___________________________
3. ___________________________
4. ___________________________
SOCIAL HISTORY

☐ Married  ☐ Single  ☐ Children? Number: ________

Are you currently employed? Yes ☐ No ☐  Current position: ____________________________

Are you disabled? _________ If YES, how long? ____________________________

Do you drink alcohol? _________ If YES, how often? _________ Do you smoke? If YES, how often? _________

FAMILY HEALTH HISTORY

Has anyone in your immediate family (siblings, parents, children) experienced any of the following conditions? Indicate their relationship to you in the space next to the box:

☐ Heart disease (heart attack) ____________________________

☐ Lung disease/ Asthma ____________________________

☐ Diabetes ____________________________

☐ Depression ____________________________

☐ Seizures ____________________________

☐ Cancer – type? ____________________________

☐ High blood pressure ____________________________

☐ Kidney Disease/ dialysis ____________________________

☐ Thyroid problem ____________________________

☐ Alzheimer’s/Parkinson’s disease ____________________________

☐ Stroke ____________________________

☐ Other issues ____________________________

REVIEW OF SYSTEMS: Please indicate any of the following symptoms you are experiencing:

General

Y N Don’t Know

☐ ☐ ☐ Fever, chills, sweats

☐ ☐ ☐ Loss of appetite, weight loss

Eyes

Y N Don’t Know

☐ ☐ ☐ Eyes irritation/infection

☐ ☐ ☐ Glaucoma/cataract/eye surgery

☐ ☐ ☐ Wear glasses/contacts

ENT/Mouth

Y N Don’t Know

☐ ☐ ☐ Earache/ringing

☐ ☐ ☐ Sinusitis, runny nose, allergies

☐ ☐ ☐ Oral ulcerations

Respiratory

Y N Don’t Know

☐ ☐ ☐ Asthma, emphysema/bronchitis

☐ ☐ ☐ Cough

☐ ☐ ☐ Recent chest x-ray

☐ ☐ ☐ Tuberculosis

Cardiovascular

Y N Don’t Know

☐ ☐ ☐ Short of breath

☐ ☐ ☐ Irregular heartbeat

Psychiatric

Y N Don’t Know

☐ ☐ ☐ Depression

☐ ☐ Cox Anxiety disorder

Gastrointestinal

Y N Don’t Know

☐ ☐ ☐ Nausea/vomiting

☐ ☐ ☐ Diarrhea/constipation/bloody stools

☐ ☐ ☐ Heartburn/indigestion/reflux disease

☐ ☐ ☐ Polyps/colonoscopy

Genitourinary

Y N Don’t Know

☐ ☐ ☐ Increased urination

☐ ☐ ☐ Diarrhea/constipation/bloody stools

Musculoskeletal

Y N Don’t Know

☐ ☐ ☐ Leg cramps

☐ ☐ ☐ Arthritis/arthralgias/gout

☐ ☐ ☐ Soft tissue/bony trauma

☐ ☐ ☐ Congenital deformity

Skin

Y N Don’t Know

☐ ☐ ☐ Leg ulcers/discoloration of feet/legs

☐ ☐ ☐ Bruising/bleeding tendencies

☐ ☐ ☐ Acne

Reproductive

Y N Don’t Know

☐ ☐ ☐ Normal periods

☐ ☐ ☐ Absent periods

☐ ☐ ☐ Irregular periods

☐ ☐ ☐ Post-menopausal

☐ ☐ ☐ Pre-menopausal

☐ ☐ ☐ Hysterectomy

Please sign below:

Patient Signature: ____________________________

Affix Patient Label Here