



1334 Marsh Street
San Luis Obispo, CA 93401
805-543-2724 phone
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Patient Questionnaire

Name: _____ Date: _____

1. Contact information:

Address: _____

Phone number(s): _____

2. What problem brings you to the office today?

3. Please circle any symptoms you have:

Do you have any of the following?

- a. **General Symptoms:** weight change, fevers, chills, sweats, fatigue, sleep disorder, loss of appetite?
- b. **Eyes, Ears, Nose, Mouth, Throat:** headache, change in vision, hearing, voice, sore throat, congestion, nasal discharge?
- c. **Respiratory:** cough, excessive sputum, shortness of breath at rest, with exertion, while lying flat, or at night; wheezing, chest tightness, smoking?

- d. **Cardiovascular:** chest pressure, angina, palpitations, foot swelling, leg walking cramps.
- e. **Gastrointestinal:** trouble swallowing, nausea, vomiting, constipation, diarrhea, blood with stool, abdominal pain.
- f. **Genitourinary:** excessive urinary frequency or urgency, painful urination, blood in the urine, sexual problems, private part discharge or lesions. Awaken to urinate how often each night?
- g. **Muscles/joints:** weakness, joint pain or swelling.
Skin: rash, changing moles, slow wound healing, color change
- h. **Neurologic:** areas of weakness, numbness, change in sensation, tremor, speech difficulty, memory loss, or major neurological symptoms
Psychiatric: change in mood, personality, suicide plans, sense of invincibility, racing thoughts, hearing or seeing things not there.
- i. **Endocrine:** excessive thirst, excessive urination, frequently too hot? too cold?

4. Please list your allergies below:

5. Please list your medicines below:

6. Would you like a printed list of your medications?

Yes?

No?

7. Please sign & date here: _____