Gagneja Health
Priti Gagneja, MD FACP

Health Questionnaire

Name:_____ Date of Birth:_____ Date:_____

What is/are your chief symptom(s) or medical problem(s) at this time?_____

_____

Surgical history:

Surgical/anesthetic complications?_____

Blood transfusions?_____

Medical history:

Allergies:_____

Medications:_____

Family history:

Mother:_____

Father:_____

Brothers:_____

Sisters:_____

Children:_____

Others:_____

Social history:

Birthplace:_____ **Marital Status:** ☐Single ☐Married ☐Divorced ☐Widowed ☐Other

Children: ☐Yes ☐No **Education:** ☐High School ☐College or University ☐Trade School ☐Other

Occupations (past and present):_____

Spiritual/religious affiliations:_____

What form of exercise do you get?_____

Hobbies and interests:_____

Habits:

Do you smoke or vape? ☐ Yes ☐ No If yes, how often per day? _____
If applicable, what year did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, what is your average number of drinks / week? _____

Do you drink caffeine? ☐ Yes ☐ No If yes, how many cups per day? _____

Do you currently use any other drugs that aren't prescribed to you? ☐ Yes ☐ No

In the past, have you used any other drugs that weren't prescribed to you? ☐ Yes ☐ No

REVIEW OF SYSTEMS

General (Check all that apply)**:**

- ☐ I frequently feel ill.
- ☐ I have fever, chills, or sweats.
- ☐ I have lost or gained weight in the last year. If checked, please specify. _____
- What is the most you have ever weighed? _____
- ☐ I have difficulty, falling asleep, staying asleep, loud, snoring, or need for daytime sleep.
- ☐ I find myself falling asleep when it is not intended or dangerous.
- ☐ My legs jerk frequently or feel restless before or during sleep.
- ☐ I have difficulty experiencing pleasure.
- ☐ I've previously had or currently have an emotional illness.
- ☐ I experience frequent mood swings.
- ☐ I have feelings of worthlessness or guilt.
- ☐ I have difficulty concentrating.
- ☐ I experience intrusive or unwanted thoughts.
- ☐ I feel a need to do unnecessary tasks.
- ☐ I have recurrent thoughts of death.
- ☐ I consider myself a nervous person.
- ☐ I sometimes feel like I should cut down on my alcohol consumption.
- Was there ever a time when you consumed more alcohol than you do now? ☐ Yes ☐ No
- ☐ It's not unusual for others to criticize my drinking.
- ☐ I'm currently in a relationship where I have been threatened or abused by my partner.
- ☐ I wear my seatbelt every time I'm in a vehicle.
- ☐ I need help with shopping, preparing meals, house, work, laundry, managing my medications, and/or other activities of daily living.
- ☐ My home has rugs or other tripping hazards in it.
- ☐ My home has grab bars in the bathroom.
- ☐ My home has handrails by all staircases.
- ☐ My home has poor lighting.
- ☐ I am currently on disability.
- ☐ I have an advanced directive. If checked, please provide a copy.

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Skin (Check all that apply)**:**

- ☐ I have an itchy skin rash.
- ☐ I have lumps, growths, or changing moles.
- ☐ I have noticed significant changes in my hair or nails.
- ☐ I have a history of skin cancer.

Please provide your dermatologists name, if applicable. _____

_____

Eyes (Check all that apply)**:**

- ☐ I've experienced double vision, blurry vision, and/or blind spots.
- ☐ I wear glasses and/or contact lenses.
- ☐ I have glaucoma or cataracts.
- ☐ I've previously had eye injuries or infections.
- ☐ I've had surgery or laser treatment for my eyes.

When was your last eye exam? _____

_____

If applicable, please list your ophthalmologist or optometrist. _____

_____

_____

Ears (Check all that apply)**:**

- ☐ I currently have ear problems.
- ☐ I am hard of hearing.
- ☐ I have ringing in the ears.
- ☐ Others have told me I am hard of hearing.

When was your last audiogram? _____

_____

If applicable, please list or audiologist or ENT physicians name. _____

_____

Nose and throat (Check all that apply):

- ☐ I've experienced sinus trouble.
- ☐ I have a fever and/or seasonal allergies.
- ☐ I'm experiencing hoarseness or a change in my voice.
- ☐ I get nosebleeds often.
- ☐ I'm experiencing an alteration in taste or smell.
- ☐ I have a history of radiation treatment to the face.
- ☐ I have a history of thyroid disease.

Chest (Check all that apply):

- ☐ I have asthma or experience wheezing.
- ☐ I experience shortness of breath.
- ☐ I have a frequent cough.
- ☐ I'm coughing up discolored mucus.
- ☐ I've been exposed to asbestos in the past.

If applicable, list your last TB test date. _____

Health Questionnaire

Heart (Check all that apply)**:**

- ☐ I have high blood pressure.
- ☐ I have elevated cholesterol.
- ☐ I have chest pain.
- ☐ I have swollen ankles.
- ☐ I have other heart problems.
  If checked, please specify. _____
  _____
- ☐ I have had a heart attack.
- ☐ I have a heart murmur or an abnormal heart valve.
- ☐ I have an irregular heartbeat.
- ☐ I have had an aniogram before.
- When was your last EKG? _____
- When was your last stress test? _____

Gastrointestinal (Check all that apply)**:**

- ☐ I have trouble swallowing.
- ☐ I experience frequent heartburn.
- ☐ I experience nausea and/or vomiting.
- ☐ I experience abdominal pain.
- ☐ I have had an ulcer before.
- ☐ I have gallbladder disease.
- ☐ I have a liver or pancreas problem.
- ☐ I experience constipation or diarrhea often.
- ☐ I have hemorrhoids or other rectal problems.
- ☐ I experience black or bloody stools.
- ☐ I have been diagnosed as having colon polyps.
- When was your last colonoscopy? _____

Genitourinary (Check all that apply):

- ☐ I have frequent urination.
  How many times do you urinate at night? _____
- ☐ I have pain with urination.
- ☐ I have blood in my urine.
- ☐ I have a history of kidney stones.
- ☐ I have trouble starting and stopping urination.
- ☐ I lose control of my bladder often.
- ☐ I have had a venereal disease.
- ☐ I am having sexual problems.

For men:

- ☐ I have a history of prostate troubles.

For women:

- When was your last Pap smear? _____
- Mammogram? _____
- ☐ I have hot flashes.
- Last menstrual period? _____
- ☐ I am using birth control. If checked, which form of birth control control? _____
- Number of pregnancies? _____
- ☐ I experience vaginal pain or discharge.
- ☐ I experience breast pain, lumps, or discharge.
- ☐ I am on hormone replacement therapy.

Bones and joints (Check all that apply)**:**	
☐ I have joint pain and stiffness.	☐ I have osteoporosis.
☐ My joints get red and swollen.	Date of last osteoporosis screening: _____
☐ I have back pain that limits my activity.	☐ I have muscle weakness or pain.
☐ I suffer from neck pain.	☐ I get muscle cramps often.
☐ I have a history of gout.	☐ I've lost height.

Neurological (Check all that apply)**:**	
Are you right or left handed? ☐ Right-handed ☐ Left-handed	☐ I experience vertigo.
☐ I experience frequent headaches.	☐ I have balance problems.
☐ I experience fainting or loss of consciousness.	☐ I frequently experience lightheadedness.
☐ I have had a seizure and/or epilepsy.	☐ I experience numbness or tingling in my arms and/or legs.