MILLIKEN MEDICAL SYMPTOM QUESTIONNAIRE

PLEASE FILL OUT THE FORM BELOW **Date**

LEGAL FIRST NAME:_____**LAST NAME:**_____ **MI:**_____BIRTH DATE:_____

Gender: Male/Female

MARITAL STATUS: _____Single _____Married ____ Divorced ____Widow(er)

CURRENT MEDICATIONS/SUPPLEMENTS:

	Name	**Dose**	**Frequency**
1)			
2)			
3)			
4)			
5)			
6)			

ALLERGIES:_____

IMMUNIZATIONS: (please specify the date you last had one)

Tetanus:_____ Shingles:_____
Pneumonia:_____ Flu vaccine:_____
Other(s):_____

DO YOU SMOKE? **Yes** **No** IF SO, FOR HOW LONG?_____ HOW MANY PACKS PER DAY?_____
FORMER SMOKER? **Yes** **No**

ALCOHOLIC BEVERAGES? ___1-2 ___ 3-5 ___ >5 PER DAY OR WEEK?

DO YOU USE ANY NARCOTICS/STREET DRUGS/CONTROLLED SUBSTANCES?_____
IF YES, WHAT KIND?_____

ARE YOU SEXUALLY ACTIVE: **Yes** **No** IF YES, CONTRACEPTION TYPE?_____

SERIOUS INJURIES/FRACTURES:_____

SURGERIES/HOSPITALIZATIONS: (please list date(s), hospital(s), and surgeon(s) if known)

_____
_____
_____

PAST MEDICAL HISTORY OR PAST DIAGNOSES:_____
_____

FAMILY HISTORY: (please note health and/or health changes of close relatives)

	Age	**Present Health**	**Deceased (Cause)**
FATHER:	_____	**Good/Poor**	**Y N** _____
MOTHER:	_____	**Good/Poor**	**Y N** _____
SIBLINGS:	_____	**Good/Poor**	**Y N** _____
	_____	**Good/Poor**	**Y N** _____

	Age/Sex	**Present Health**	**Deceased (Cause)**
CHILDREN	**___ M F**	**Good/Poor**	**Y N** _____
	___ M F	**Good/Poor**	**Y N** _____

PLEASE SEE OTHER SIDE

Please place an "X" next to symptoms you have had in last 6 months.

URINARY

___ NIGHT FREQUENCY more than once
___ DAY FREQUENCY more than every 2 hours
___ BURNING ON URINATION
___ DELAYED/WEAK URINE STREAM
___ BROWN/BLACK/BLOODY URINE
___ STD'S (sexually transmitted disease)

RESPIRATORY

___ WHEEZING
___ COUGHING SPELLS
___ SHORTNESS OF BREATH
___ CHEST COLDS(more than two per year)
___ POSITIVE SKIN TEST (tuberculosis)
___ TB (tuberculosis)-PREVIOUS HISTORY

MOOD

___ LITTLE INTEREST IN DOING THINGS
___ LONELY, DEPRESSED, HOPELESS
___ WORRY A LOT
___ UNREASONABLE FEARS/PHOBIAS

GENERAL

___ FATIGUE, LACK OF ENERGY
___ FEVER/CHILLS
___ UNEXPLAINED WEIGHT LOSS
___ SLEEPING DIFFICULTIES

FEMALE:

DATE OF LAST PERIOD_____
___ HEAVY BLEEDING DURING PERIOD
___ HOT FLASHES
___ HYSTERECTOMY- YEAR____
DATE OF LAST PAP TEST _____

___ BLEEDING BETWEEN PERIODS
___ SELF BREAST EXAMS
___ MISCARRIAGES (if yes, #___)
PREGNANCIES:_____

(For office use)
Reviewed by:_____
Date:_____

EARS, EYES,NOSE,THROAT

___ EYESIGHT CHANGES
___ PERIODIC EYE EXAM-DR._____
___ EYE PAIN OR ITCHING
___ HEARING DIFFICULTIES
___ HEARING AID
___ NASAL CONGESTION
___ HOARSE VOICE

NEUROLOGICAL

___ FREQUENT SEVERE HEADACHES
___ DIZZY SPELLS
___ MIGRAINE HEADACHES
___ COMPLETE BLACKOUTS
___ CONVULSIONS
___ PARALYSIS OR NUMBNESS
___ MEMORY PROBLEMS
___ WEAK OR UNSTEADY GAIT

CARDIOVASCULAR

___ RACING HEART/MISSED BEATS
___ PAIN OR TIGHTNESS IN CHEST
___ SHORT OF BREATH LAYING FLAT
___ LEG CRAMPS WHILE WALKING
___ ANKLE/LEG SWELLING

ORTHOPEDIC

___ LOW BACK PAIN
___ PAIN RADIATING DOWN LEGS
___ OTHER JOINT/MUSCLE PAINS

MALE:

___ SEXUAL DYSFUNCTION
___ TESTICULAR CHANGES

DIGESTIVE

___ HEARTBURN
___ BLOATED STOMACH
___ NAUSEA-feel like vomiting
___ CONSTIPATION
___ DIARRHEA-loose stools
___ BLOOD TRANSFUSION PRIOR TO 1992