

Family Medicine Associates of Midland, P.C.

Name: _____ Date: _____
Patient's MR Number: _____

I've developed this questionnaire to help me get a little better history on how things have gone since our last visit.

This was designed primarily for patients who have one of the following – diabetes, high blood pressure and/or some type of heart disease.

Since this was designed for a number of diseases, some questions may not make sense for the problems you have, but bear with me and answer them the best you can. All you need to do is circle the response. I will go into more detail as we talk, so you do not have to write down the details.

General:

Has your appetite remained good?	Yes	No
Have you lost weight?	Yes	No
Have you been more tired than usual?	Yes	No
Have you gained weight?	Yes	No
Coffee – how many cups per day? Less 0 1 2 3 4 5 More	Caffeine	Decaf
Tea – how many cups per day? Less 0 1 2 3 4 5 More	Caffeine	Decaf
Alcohol – how many drinker per WEEK? Less 0 1 2 3 4 5 More		
wine beer other		

Head, eyes, ears, nose and throat:

Have you had spells of double vision?	Yes	No
Have you had spells of actual loss of vision?	Yes	No
When was the last time you saw the eye doctor? _____		
Have you had problems with nose bleeds?	Yes	No

Breathing:

Have you had trouble with coughing?	Yes	No
If so, coughing – a little a lot		
If you have been coughing – is there any mucous?	Yes	No
What is the color of the mucous most of the time? _____		
Have you been <i>MORE</i> short of breath than usual?	Yes	No
Have you had trouble with wheezing?	Yes	No
Have you been waking up at night short of breath?	Yes	No
If you have been short of breath, can you circle activities that cause this:		
Short Walks Doing Laundry Vacuuming Walking up one Flight of Stairs		
Shoveling Snow Mowing Lawn Doing Dishes Making the Bed		
Walking Around Stores Carrying Groceries Doing Yard Work Ironing		
Walking Through Parking Lots		

Heart:

Have you had any heart palpitations, racing or flutter feeling?	Yes	No
Do you have leg cramps in your calf or thigh when walking?	Yes	No
Do you have cramps in your legs at night?	Yes	No
Have you had any spells of chest pain or pressure, chest tightness, jaw or left shoulder pain?	Yes	No
Have you had any swelling in the ankle area from extra fluid?	Yes	No
How many pillows do you use to sleep on at night? 1 2 3 4		
Do you have to sleep in a chair at night?	Yes	No
Do you get light-headed or dizzy when getting up out of bed or a chair?	Yes	No

Gastrointestinal:

Do you have heartburn enough to take something for it more than once a week?	Yes	No
Do you have problems with diarrhea?	Yes	No
Do you have problems with constipation?	Yes	No
Do you ever notice blood on the toilet tissue when wiping?	Yes	No
Do you have black stools or blood in or on your stools?	Yes	No
Do you have problems with a lot of bloating or belly pain?	Yes	No

Genitourinary:

Do you wake up at night to urinate? If so, how many times? 0 1 2 3 4 5 6 7		
Have you seen blood in the urine?	Yes	No
Do you have problems with leaking urine?	Yes	No
Does it seem hard to empty your bladder – straining more?	Yes	No
Are you urinating a lot more often?	Yes	No

Neurologic:

Have you had any fainting spells and/or “almost” fainting spells?	Yes	No
Have you been concerned about any “mini”-strokes?	Yes	No
Have you had any problems with dizziness or change in balance?	Yes	No
Have you had any weakness or numbness of one side of the body?	Yes	No

Skin:

Have you noticed any abnormal color to moles?	Yes	No
Are there any skin spots you want me to look at?	Yes	No
Do you often have bruises that are bigger than a dime in size?	Yes	No
Does your skin heal well if there have been simple cuts or scrapes?	Yes	No

Reviewed: _____