Dear Patient,

At the Crossville Medical Group we are attempting to update our medical records and we need your assistance. Please complete the enclosed questionnaire, as best you can and return it to our office before your next appointment. If you have trouble filling this out, do not worry, just bring it in with you and my assistant will be happy to help you. If you need more room to write, you can use the backs of these sheets or use a separate sheet.

Thank you very much for your time and attention.

PATIENT QUESTIONNAIRE:

Patient Name:		Date of birth:			
Address:					
City/State		Zip		Phone #	
Primary Care Physician:		Next Appointment			

Please list below your current and past medical problems (such as high blood pressure, chest pains, stomach problems, etc....)

1		8	
2		9	
3		10	
4		11	
5		12	
6		13	
7		14	

Do you have any known drug allergies? No Yes,

_____

Please list your current medications:

Name of Medication	Dose /milligrams	How may times a day do you take it?

MEDICATION ALLERGIES:

IMMUNIZATIONS:
When did you have your last:

Flu Shot _____ Pneumovax _____ Tetanus_____ Mammogram _____

Please check the following surgeries that **you have had**, with the date and surgeon.

( ) Abdominal aneurysm repair
( ) Appendectomy
( ) Back surgery
( ) Breast biopsy, Right or Left
( ) Breast removal
( ) Carotid surgery - Right or Left
( ) Cataract surgery - Right or Left
( ) Colon removal - Partial
( ) Gallbladder removed
( ) Hernia repair - Right or Left
( ) Heart balloon surgery
( ) Hemorrhoid surgery
( ) Hiatal hernia repair
( ) Hip replacement, Right or Left
( ) Hysterectomy, complete
( ) Knee Replacement, Right or Left
( ) Ovaries removed - Right, Left, Both
( ) Pacemaker placement
( ) Prostate - TURP
( ) Prostate removal, complete
( ) Skin cancer removal
( ) Spleen removal
( ) Stomach removal - partial
( ) Thyroid removal, Partial or Total
( ) Tonsil and adenoid removal
( ) Vasectomy

Other:

_____ _____

_____ _____

_____ _____

_____ _____

Have you ever had a blood transfusion? ( ) No ( ) Yes, When _____

Please list below medical problems which run in your family (mother, father, sisters, brothers, etc...)
Specifically, please list any history in your family of breast, colon, ovarian or prostate cancer.

Family Member	Illness

Occupation: _____

Type of Exercise you do on a routine basis: _____ _____

How often do you exercise: ( ) daily ( ) 4 to 7 days per week ( ) 3 to 5 days per week
( ) Less than 3 days per week ( ) Occasionally ( ) Rarely ( ) Never

Do you smoke cigarettes?
( ) Yes, how many packs per day _____ for how many years _____?
( ) Stopped smoking, when _____?
( ) Does not smoke.

Do you drink alcohol?
( ) Yes, how often? ( ) daily ( ) 2-3 times a week ( ) weekly ( ) Occasionally ( )Rarely
( ) Does not drink alcohol.

Do you wear your seatbelt?
( ) Always ( ) Usually ( ) Sometimes ( ) Rarely ( ) Never

If you ride a bicycle, do you wear a helmet? ( ) Yes ( ) No

If you ride a 4-wheeler or motorcycle, do you wear a helmet? ( ) Yes ( ) No

Again, we thank you for your help.

CROSSVILLE MEDICAL GROUP
PROFESSIONAL ASSOCIATION