Daryl S. Marx, LLC
Medical Questionnaire

Patient ID# ___________________________
Name _______________________ Date of Birth ________ Age___________ Date ___________
Family Physician________________________ Referring Doctor ______________________________
Reason For Visit (Chief Complaint) ____

Past Surgical History **None Apply or** **(Check That Apply To You)**

Appendectomy
Breast Biopsy/Mastectomy
Heart Surgery
Hemorrhoidectomy
Hernia
Tonsillectomy
Hysterectomy Partial or Complete (please circle one)
Pacemaker
Prostate Biopsy
Removal Of Gallbladder
Sinus
Spinal Surgery Neck and/or Back (please circle one) year? _______
Other ____

Past Medical History **None Apply or** **(Check That Apply To Your)**

Aids
Asthma
Bronchitis
Cancer
Diabetes
Diverticulitis
Emphysema
Heart Attack
High Blood Pressure
Kidney Stones
Lung Problems
Osteoarthritis
Pneumonia
Rheumatoid Arthritis
Seizures
Strokes
Thyroid Problems
Tuberculosis
Ulcers
Other Conditions (please list) ____

Medications Taken Daily **None** **(List all and Doses)**

_________________________ _________________________ _________________________
_________________________ _________________________ _________________________
_________________________ _________________________ _________________________
_________________________ _________________________ _________________________
_________________________ _________________________ _________________________

Allergies To Medicine? YES OR NO
Please list all ____

Social History

Alcohol yes or no __________
Chew Tobacco yes or no amount __________
Drug Use yes or no amount __________
Smoke yes or no packs per day? __________
STD herpes venereal disease other

Family History

Bleeding Problems
Cancer
Diabetes
Heart Problems
High Blood Pressure
Ostoearthritis
Rheumatoid Arthritis
Strokes
Turberulosis

Review Of Systems **None Apply** **(Check Any That Apply To You)**

Bleeding Problems
Blood In Stool
Blood In Urine
Chest Pain
Constipation
Coughing Up Blood
Depression
Diarrhea
Difficulty Hearing
Dizziness
Fever
Frequent Urination
Headaches
Heart Murmur
Irregular Heartbeat (Palpations)
Memory Loss
Night Sweats
Nose Bleeds
Numbness In Arms
Painful Urination
Phlebitis/Blood Clots
Rashes
Shortness Of Breath
Stomach and Abdominal Pain
Swollen Ankles
Trouble with Urination
Trouble with Vision / Requires Glasses or Contacts
Weight Loss

Women: Are You Pregnant? yes or no
Do You Take Birth Control Pills? yes or no
Last Menstrual Cycle __________
No Prior Female Problems
Other ____________________________

Men: No Prior Problems
Prostatitis
Sexual Disfunction
Other ____________________

OFFICE USE ONLY

Reason For Visit (Chief Complaint) ____

History of Present Illness

Days ____
Weeks ____
Months ____
Years ____

PHYSICAL EXAM:____
____
____
____

VITAL SIGNS: ____
____

ASSESMENT: ____
____
____

PLAN: ____
____