Daryl S. Marx, LLC
Medical Questionnaire

Name ________________________ Date of Birth ________ Age___________ Date ___________

Family Physician_________________________ Referring Doctor _______________________________

Reason For Visit (Chief Complaint) ____

Past Medical History **__None Apply or** **(Check That Apply To Your)**

___ AIDS	___Diverticulitis	___Kidney Stones	___Strokes
___ Asthma	___Emphysema	___Lung Problems	___Thyroid Problems
___ Bronchitis	___GI Reflux	___Osteoarthritis	___Tuberculosis
___ Cancer	___Heart Attack	___Pneumonia	___Ulcers
___ Coronary Heart Disease	___Stent Placement	___Rheumatoid Arthritis	
___ Diabetes	___High Blood Pressure	___Seizures	

___Sleep Apnea: ___use CPAP machine ___do not use CPAP machine
___Any other heart problems or other conditions(Please list):

____
____

Family History-1st degree relatives only-please write mother, father, sister or brother or child

Bleeding Problems	_______	Heart Problems	_______	Rheumatoid Arthritis	_______
Cancer	_______	High Blood Pressure	_______	Strokes	_______
Diabetes	_______	Osteoarthritis	_______	Tuberculosis	_______

Social History-Circle

Alcohol use	yes or no	How much per day? _________	Per Week?_______
Chew Tobacco	yes or no	How many times per day? ____	Per Week? _______
Drug Use	yes or no	What kind of drugs? _________	How Often? __________
Smoke	yes or no	Packs per day?_________	How many years?_______
		If you stopped smoking-When? _____	Number of years you smoked? ____
STD	____ herpes	___venereal disease	___other

Allergies To Medicine? YES OR NO
Please list all ____

Allergic To Latex? YES OR NO

Allergic To Other Products/Foods/ or other Environmental factors? Please List:

____
____

Medications Taken Daily **__None** **(List all and Doses)**

__________________________	__________________________	__________________________
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________

Past Surgical History	None Apply or	(Check That Apply To You)
___Appendectomy	___Hernia Repair	___Tonsillectomy
___Breast Biopsy	___Hysterectomy-Complete/Partial	___Back Surgery(see below)
___Breast Lumpectomy	___Lap-Band placement/removal	___Neck (spinal surgery)
___Breast Implants	___Pacemaker insertion	___Lower Back (spinal surgery)
___Colon Surgery	___Prostate Surgery	___Other Surgeries:
___Gallbladder Removal	___Sinus Surgery	______________________
___Heart Surgery	___Stomach Surgery	______________________
___Heart Stents	___Splenectomy	______________________
___Hemorrhoid Surgery	___Thyroid Surgery	______________________

REVIEW OF SYSTEMS: check if it applies to you in the past or present

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
___	___	Bleeding problems	___	___	Heart Murmur	___	___	Trouble with Vision
___	___	Blood in stool	___	___	Irregular Heartbeat	___	___	Require Glasses/Contacts
___	___	Blood in urine	___	___	Memory Loss	___	___	Weight Loss
___	___	Chest pain	___	___	Night Sweats			
___	___	Constipation	___	___	Nose Bleeds			
___	___	Coughing Up Blood	___	___	Numbness In Arms			
___	___	Depression	___	___	Painful Urination			
___	___	Diarrhea	___	___	Phlebitis/Blood Clots			
___	___	Difficulty Hearing	___	___	Rashes			
___	___	Dizziness	___	___	Shortness of Breath			
___	___	Fever	___	___	Stomach and Abdominal Pain			
___	___	Frequent Urination	___	___	Swollen Ankles			
___	___	Headaches	___	___	Trouble with Urination			

Do you wear a CPAP machine at night? Yes or No
Have you been told by a physician to wear a CPAP machine? Yes or No

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 Dysfunction
Other ____________________

DISCLAIMER:
THIS QUESTIONAIRE CONTAINS IMPORTANT QUESTIONS THAT MUST BE FILLED OUT PRIOR TO YOUR OFFICE VISIT. THE PHYSICIAN RELIES ON THIS INFORMATION TO GIVE YOU THE BEST CARE POSSIBLE. IF YOU DO NOT COMPLETE THIS FORM ACCURATELY AND COMPLETELY, IT COULD ADVERSELY AFFECT YOUR CARE.

I HAVE READ THE DISCLAIMER ABOVE AND HAVE FILLED OUT THIS FORM ACCURATELY AND COMPLETELY. I WILL NOTIFY THE PHYSICIAN OF ANY CHANGES TO MY HEALTH OR MEDICATIONS AT EACH OFFICE VISIT.

MY NAME:________________________________ **DATE:**________________