THE POLYCLINIC

DAVID A. IBRAHIM, MD
PATIENT QUESTIONNAIRE
INITIAL EVALUATION

Date: _____

Patient Name: _____

Family/Primary Doctor: _____ **Phone:** _____

Family/Primary Doctor's Address: _____

Who referred you to The Polyclinic? (name & address please) _____

_____

INSTRUCTIONS: Please complete the following questionnaire before you see the doctor. ***Circle the word or phrase that best describes your situation. You may select more than one answer per question.*** Answer the question in as much detail as possible. Write additional information in the margins. The information you provide will help your doctor to more accurately understand your problem(s) and develop an appropriate plan of treatment for your care. **THANK YOU.**

Age: _____ **Sex:** _____ **Marital Status:** _____ **Handed: R/L**_____

Height: _____ **Weight:** _____

Occupation: _____

What are you seeing the doctor for? _____

Duration of Symptoms: _____

When did the problem first start or when did the injury occur? _____

Is this injury work related? Yes / No **If so, what is your L&I number?** _____

Have you seen a doctor in the past for this problem or injury? Yes / No If yes, who and when? _____

_____

Explain in your own words how this injury occurred: _____

_____

_____

_____

What treatment have you had? _____

_____

_____

_____

TELL US ABOUT YOURSELF AND YOUR PAST MEDICAL HISTORY:
If you are a Polyclinic patient and have recently seen your primary care doctor, skip to page 4

Circle anything listed below to which you are allergic:

(A) No known allergies
(B) Penicillin
(C) Tetracycline
(D) Sulfa
(E) Morphine
(F) Erythromycin
(G) Codeine
(H) Iodine/Betadine
(I) Radiographic Dyes
(J) Adhesive Tape
(K) Other (Specify): _____

Circle any of the medical problems listed below that you have now:

(A) I have no known medical problems.
(B) Hypertension (high blood pressure)
(C) Coronary artery disease
(D) Peripheral vascular disease
(E) Adult onset diabetes
(F) Childhood onset diabetes
(G) Past heart attack
(H) Asthma
(I) Ulcers
(J) Hepatitis A / B / C
(K) Cancer
(L) Tuberculosis
(M) Liver disease
(N) Seizure disorder
(O) Thyroid disease
(P) Emphysema
(Q) COPD/Lung problem
(R) Immune disorder
(S) Overweight
(T) Osteomyelitis
(U) Blood Clot (DVT)
(V) Osteoporosis
(W) Hyperlipidemia (high cholesterol)
(X) Other (Specify): _____

_____

How much alcohol do you consume?

(A) I'm a non-drinker
(B) I'm a recovering alcoholic
(C) I drink only occasionally
(D) I drink weekends only
(E) An average of 1-2 drinks per day
(F) An average of 2-3 drinks per day
(G) An average of 3-4 drinks per day
(H) More than 6 drinks a day

Do you now, or have you ever smoked cigarettes?

(A) Yes, I am currently a smoker
I smoke (circle one) 1 2 3 _____ packs/day
I have smoked for _____ years
(B) No, but I used to smoke I smoked for _____ years
(C) No, I have never smoked

Do you now, or have you ever used drugs?

(A) Recreational
(B) Cocaine
(C) Marijuana
(D) Other (Specify): _____

Has anyone in your immediate family ever had any of the following? Circle the illness that apply.

(A) None known
(B) Cancer
(C) Leukemia
(D) Stroke
(E) Hypertension
(F) Coronary artery disease
(G) Rheumatic fever
(H) Diabetes
(I) Hypothyroidism
(J) Colitis
(K) Bleeding tendency
(L) Asthma
(M) Tuberculosis
(N) Seizure disorder
(O) Alcoholism
(P) Other (Specify): _____

Circle any surgeries listed below you may have had. Indicate the year of the surgery:

(A)	No previous surgeries	(G)	Hysterectomy _____
(B)	Appendectomy _____	(H)	Lumber laminectomy _____
(C)	Cataract extraction _____	(I)	Mastectomy _____
(D)	By-pass / open heart _____	(J)	Tonsillectomy _____
(E)	Gall bladder _____	(K)	Prostate surgery _____
(F)	Hernia repair _____	(L)	Other (Specify): _____

Any previous broken bones: _____

What medications are you currently taking? Please include both prescription and non-prescription medications. You may use the back for additional space. (If you have a Polyclinic doctor and were recently seen by your Polyclinic doctor, simply write "Polyclinic patient". Otherwise, please complete if we do not have your most recent medication list on file).

Medications	**Dose**	**# Times a Day**

Please provide your Pharmacy information: Name: _____ Phone#: _____

Pharmacy Address/Location: _____

Would you like your medication sent to your Pharmacy electronically? Yes_____ No _____

Please circle any anti-inflammatory medications listed below which you have taken in the past. Please include all prescription and non-prescription medication and samples, which were provided.

Advil Arthrotec Daypro Ibuprofen Lodine (Etodolac) Naprelan Naproxen

Oruvail Sulindac Motrin Diclofenac Other: _____

Please circle any of the following side effects while you were currently taking any of the above anti-inflammatory medications.

Nausea Diarrhea Gastric Ulcers Upset stomach Vomiting Stool discoloration

Other: _____

Are you currently taking any of the following on a regular basis?

Aspirin Coumadin (Warfarin) Cytotec Heparin Maalox Mylanta Pepcid Plavix (Clopidogrel)

Pradaxa (Dabigatran) Prevacid Prilosec Tagamet Xarelto (Rivaroxaban) Zantac

Have you ever had a blood clot in your leg or lungs? Yes No

Blood transfusion: Yes / No Year: _____

TELL US ABOUT YOUR HEALTH IN GENERAL: Do you have any of the following? Circle YES or NO.

SYMPTOMS			**COMMENTS**
Chest Pain	Yes	No	_____
Dizziness	Yes	No	_____
Dry cough	Yes	No	_____
Productive cough	Yes	No	_____
Difficulty breathing	Yes	No	_____
Irregular heartbeat	Yes	No	_____
Swelling in the legs	Yes	No	_____
Lack of appetite	Yes	No	_____
Nausea	Yes	No	_____
Vomiting	Yes	No	_____
Diarrhea	Yes	No	_____
Constipation	Yes	No	_____
Abdominal cramping	Yes	No	_____
Varicose veins	Yes	No	_____
Bruising	Yes	No	_____
Bleeding	Yes	No	_____
Nose bleeds	Yes	No	_____
Joint pain and/or stiffness	Yes	No	_____
Muscle pain or muscle cramps	Yes	No	_____
Difficulty seeing	Yes	No	_____
Difficulty hearing	Yes	No	_____
Difficulty swallowing	Yes	No	_____
Difficulty sleeping	Yes	No	_____

Everything I have answered is true and correct to the best of my knowledge**.**

_____

Patient Signature Date

THANK YOU FOR COMPLETING THIS PATIENT QUESTIONNAIRE.
IT WILL BECOME A PART OF YOUR PERMANENT MEDICAL RECORD