



3603 Paesanos Parkway, SUITE 300 | TEL. 210-853-3967 | info@gazdaintegrativeneurology.com

Patient Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Cell Phone: (\_\_\_\_) \_\_\_\_\_

Insurance Provider \_\_\_\_\_  
 Gender \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

**ADULT PATIENT QUESTIONNAIRE**

*All of the information herein will be treated in accordance with all applicable confidentiality laws and practices and is intended solely for the use of Dr. Suzanne K. Gazda, MD.*

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Your Cell Phone: (\_\_\_\_) \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone: (\_\_\_\_) \_\_\_\_\_

**Physician and Pharmacy Information**

**Primary Care Physician (Family Practice, Internist)**  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Fax \_\_\_\_\_  
 Email \_\_\_\_\_

**Referring Physicians**  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Fax \_\_\_\_\_  
 Email \_\_\_\_\_

**Other Physician/ Provider with Whom You Would Like Us to Communicate:**  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Fax \_\_\_\_\_  
 Email \_\_\_\_\_

**Other Physician/ Provider with Whom You Would Like Us to Communicate:**  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Fax \_\_\_\_\_  
 Email \_\_\_\_\_

**Preferred Retail Pharmacy**  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Fax \_\_\_\_\_

**Mail Order/Alternate Pharmacy**  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Fax \_\_\_\_\_

**What would you like to talk about during your visit?**

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**Medical History:**

Past Medical History: Have you ever had any of the following?

- |                                      |                              |                             |  |                              |                             |
|--------------------------------------|------------------------------|-----------------------------|--|------------------------------|-----------------------------|
| Allergies                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Irregular Heart Rhythm                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anxiety Disorder                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Failure or Disease                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Stones                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bone Fracture as an Adult            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Lupus                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bronchiectasis                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Obstructive Sleep Apnea                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bronchitis                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Osteoporosis                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer (if yes, describe below)      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Peripheral Artery Disease                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pulmonary Artery Hypertension              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Coronary Artery Disease/Heart attack | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pulmonary Fibrosis(if yes, describe below) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| COPD/Emphysema                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Recurrent Infections                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cystic Fibrosis                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Restless Leg Syndrome                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Depression                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatoid Arthritis                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sarcoidosis                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| DVT or Pulmonary Embolism            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Scleroderma                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Esophageal Disease                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Seizure Disorder                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| GERD/Reflux                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sinusitis                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart or Valve Defect                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sjogren's                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hepatitis                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Skin Disorders (e.g., Psoriasis, Acne)     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| HIV/AIDS                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis (if yes, describe below)      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hypertension                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mycobacterial Infection                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hypothyroidism                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vocal Cord Dysfunction/Paralysis           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Inflammatory Bowel Disease           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |  |                              |                             |

**Please list all other medical conditions past and present:**

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**Past Surgical History**

Surgery or Procedure	Date of Procedure	Name of Surgeon/Provider

## Vaccination/Immunization History

Vaccine/Immunization	Date of Last Immunization Month / Year
Flu (Influenza) Shot	/
High Dose Flu Shot	/
Pneumovax (Pneumococcal Pneumonia)	/
Pprevnar (Pneumococcal Pneumonia)	/
Zostavax (Shingles or Herpes Zoster)	/
Tdap (Tetanus-Diphtheria-Pertussis)	/
Other:	/

## Medications Taken Regularly

Include all oral, inhaled, intravenous, and subcutaneous medications as well as all herbal medications, supplements, vitamins and over-the-counter medications. If needed, please provide a separate list.

	Medication Name	Dose	Route (Oral, Inhale)	How Often?
<i>ex</i>	<i>Lipitor</i>	<i>10 mg</i>	<i>oral</i>	<i>Once daily</i>
<b>1</b>				
<b>2</b>				
<b>3</b>				
<b>4</b>				
<b>5</b>				
<b>6</b>				
<b>7</b>				
<b>8</b>				
<b>9</b>				
<b>10</b>				
<b>11</b>				
<b>12</b>				
<b>13</b>				
<b>14</b>				
<b>15</b>				

## Allergies

Allergic to:  IV Contrast Dye: Type \_\_\_\_\_

Please list medication or severe food allergies	Describe reaction

## Oxygen and Respiratory Equipment

1. Do you use oxygen?  Yes  No

Amount: at rest \_\_\_\_\_ sleeping \_\_\_\_\_ with activity \_\_\_\_\_

Nasal Cannula  Mask  Transtracheal

2. Do you use a  CPAP or  Bi-PAP Settings: \_\_\_\_\_

3. What company delivers your oxygen or other medical equipment? \_\_\_\_\_

## Family History

Indicate if your family members have any of these diseases (GM=Grandmother, GF=Grandfather, Maternal=mother, Paternal=father's side)

Disease	Maternal			Paternal			Siblings			Children		
	Mom	GM	GF	Dad	GM	GF						
Asthma												
Autoimmune Disease Type:												
Cancer Type:												
COPD/ Emphysema												
Pulmonary fibrosis/ Interstitial Lung Disease												
Coronary artery disease/heart attack												
Diabetes Mellitus												
High cholesterol												
High blood pressure												
Frequent Pneumonia												
Pulmonary embolism (PE)												
Rheumatoid arthritis												
Stroke												
Osteoporosis/ Fragile Bones and/or Hip Fracture												
Other #1												
Other #2												

Other diseases that run in the family: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Social History**

1. Marital Status:  Single  Married/Partner  Divorced  Separated  Widowed
2. Smoking History:  I have **never** smoked  
 I currently smoke:  Cigarettes packs/day: \_\_\_\_\_  Cigar  Pipe  eCigarettes  Other  
 If you currently smoke, are you interested in quitting?  Yes  No  
 I previously smoked:  Cigarettes  Cigar  Other Age Started: \_\_\_\_\_ Age Stopped: \_\_\_\_\_  
 Average packs/day: \_\_\_\_\_ Are there smokers in home?  Yes  No  
 Smokeless tobacco:  Yes  No Number of years: \_\_\_\_\_
3. Marijuana:  Yes  No Route:  Inhaled  Edible Medical:  Yes  No
4. Street/Illicit Drugs:  Yes  No If yes, which? \_\_\_\_\_
5. Alcohol Use: Any problems with alcohol now or in the past?  Yes  No  
 Current number of drinks per week: \_\_\_\_\_ Type(s) of alcohol: \_\_\_\_\_
6. Exercise: Do you exercise regularly?  Yes  No  
 Please Describe: \_\_\_\_\_
7. Fall Risk: Have you fallen in the past 3 months?  Yes  No  
 Do you feel unsteady when standing?  Yes  No  
 Do you use a cane, walker or wheelchair?  Yes  No  
 Do you have a fear of falling?  Yes  No

**Occupational History**- Please start with the most recent job and work backwards

Job Title	Dates of Employment	Description	Health risks/exposures	Injuries/Illnesses

**Review of Symptoms:** What symptoms have you experienced in the last 6 months?

**General**

- Weight change  Yes  No
- Fatigue (impairs daily function)  Yes  No
- Fever/Chills  Yes  No
- Night sweats  Yes  No
- Decreased Appetite  Yes  No

**Eyes**

- Visual changes  Yes  No
- Dry, irritated or painful eyes  Yes  No

**ENT/Mouth**

- Ear pain or drainage  Yes  No
- Frequent sinus infections/ sinus pain  Yes  No
- Hearing changes or loss  Yes  No
- Nosebleeds  Yes  No
- Post Nasal Drip  Yes  No
- Change in voice/ hoarseness  Yes  No
- Dry Mouth  Yes  No
- Ulcers/Sores in the eyes, mouth or nose  Yes  No

**Respiratory**

- Sputum Production  Yes  No
- Chest tightness  Yes  No
- Cough lasting >1 month  Yes  No
- Shortness of breath  Yes  No
- Wheezing  Yes  No
- Chest pain  Yes  No
- Coughing up blood  Yes  No

**Cardiovascular**

- Chest pain or heaviness  Yes  No
- Palpitations  Yes  No
- Fainting or near fainting spells  Yes  No
- Swelling of feet or legs  Yes  No
- Shortness of breath lying flat in bed  Yes  No

**Gastrointestinal**

- Abdominal pain  Yes  No
- Blood in your stool  Yes  No
- Constipation  Yes  No
- Diarrhea  Yes  No
- Heartburn or indigestion  Yes  No
- Vomiting or nausea lasting >1 day  Yes  No
- Swallowing difficulty  Yes  No

**Allergic/Immunologic**

- Watery or itchy eyes  Yes  No
- Runny nose  Yes  No
- Food intolerance  Yes  No

**Psychological**

- Anxiety without clear explanation  Yes  No
- Sadness lasting days or weeks  Yes  No
- Depression  Yes  No

**Genitourinary**

- Blood in your urine  Yes  No
- Urinating that is painful or difficult  Yes  No
- Erection problems  Yes  No

**Musculoskeletal**

- Joint pain or swelling  Yes  No
- Muscle aches or tenderness  Yes  No
- Muscle weakness  Yes  No
- Stiffness in the joints  Yes  No
- Ulcers on the fingertips  Yes  No

**Skin**

- Hives  Yes  No
- Rash  Yes  No
- Non-healing ulcers  Yes  No
- Skin cancer  Yes  No
- Color change or coldness in fingertips  Yes  No
- Other changes in skin  Yes  No

**Neurologic**

- Seizures  Yes  No
- Dizziness  Yes  No
- Extremity pain or burning sensation  Yes  No
- Numbness or tingling  Yes  No

**Endocrine**

- Frequent urination  Yes  No
- Increased thirst  Yes  No
- Heat or cold intolerance  Yes  No
- Menstrual changes  Yes  No

**Hematological/Lymphatic**

- Inappropriate bleeding  Yes  No
- Unexplained bruising  Yes  No
- Swollen/Painful lymph nodes  Yes  No

**Sleep**

- Snoring  Yes  No
- Do you stop breathing at night?  Yes  No
- Excessive Daytime Sleepiness  Yes  No
- Falling asleep when you should not  Yes  No
- Difficulty falling or staying asleep  Yes  No