SUZANNE GAZDA M.D.
INTEGRATIVE NEUROLOGY

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Patient Name: _____

Date of Birth: _____

Cell Phone: (_____)_____

Insurance Provider_____

Gender_____Height_____Weight_____

GENERAL 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?

Medical History:

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

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

Please list all other medical conditions past and present:

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)	
Prevnar (Pneumococcal Pneumonia)	
Zostavax (Shingles or Herpes Zoster)	
Tdap (Tetanus-Diptheria-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?
ex	*Lipitor*	*10 mg*	*oral*	*Once daily*
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

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

RESET

SUBMIT

PRINT

Patient Name _____