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Member Doctor

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COMPREHENSIVE HEALTH QUESTIONNAIRE

Today's Date _____
 Birth Date _____
 Telephone (____) _____
 Alt. Phone (____) _____

Name _____
 Address / Apt. _____
 City, State, ZIP Code _____
 Do you receive Email? EMAIL Address _____

YOUR CURRENT PROBLEM(S): Please briefly list all current unresolved physical or mental problems that you would like to bring to my attention so those issues can be addressed, and hopefully resolved to your satisfaction.

YOUR OTHER PHYSICIANS: Please list all other physicians that you are currently seeing or have seen in the past 6 months.

YOUR PAST ILLNESSES:

Have you ever had? (Circle your response.)

- | | | |
|----------------------------------|---------------------------------------|------------------------------------|
| Measles..... No ... Yes | Meningitis..... No ... Yes | Pneumonia No ... Yes |
| Mumps..... No ... Yes | Tuberculosis No ... Yes | Diabetes..... No ... Yes |
| Chicken Pox..... No ... Yes | Hepatitis or Jaundice..... No ... Yes | Thyroid disease..... No ... Yes |
| Diphtheria No ... Yes | Gout No ... Yes | Malaria..... No ... Yes |
| Scarlet Fever..... No ... Yes | Phlebitis..... No ... Yes | Dengue Fever..... No ... Yes |
| Rheumatic Fever..... No ... Yes | Cancer..... No ... Yes | Lyme Disease..... No ... Yes |
| Whooping Cough..... No ... Yes | High Blood Pressure..... No ... Yes | Veneral Disease..... No ... Yes |
| Poliomyelitis..... No ... Yes | Stroke..... No ... Yes | HIV or AIDS..... No ... Yes |
| Childhood Eczema..... No ... Yes | Heart Disease..... No ... Yes | Addictive disorder..... No ... Yes |

Congenital abnormalities..... No ... Yes ... Details _____
 Other serious illness or disease..... No ... Yes ... Details _____
 Broken bones or severe accidents..... No ... Yes ... Details _____
 Concussions or head injuries..... No ... Yes ... Details _____
 Knocked unconscious..... No ... Yes ... Details _____

Any past surgery..... No ... Yes ... Please list all surgeries;
 Yr. _____ Details _____
 Yr. _____ Details _____
 Yr. _____ Details _____

YOUR FAMILY HEALTH HISTORY: Has any BLOOD RELATIVE ever had? (Circle your response.)

- | | | |
|-------------------------------------|-------------------------------------|---|
| Cancer..... No ... Yes | Stomach Ulcers..... No ... Yes | Arthritis or Gout..... No ... Yes |
| High Blood Pressure..... No ... Yes | Bleeding tendency No ... Yes | Osteoporosis No ... Yes |
| Stroke..... No ... Yes | Glaucoma No ... Yes | Mental Illness No ... Yes |
| Heart problems..... No ... Yes | Tuberculosis..... No ... Yes | Suicidal tendency No ... Yes |
| Diabetes No ... Yes | Asthma No ... Yes | Convulsions..... No ... Yes |
| Thyroid disease No ... Yes | Hives or Hay Fever No ... Yes | Other serious illness..... No ... Yes...What? _____ |

Relative	Age	Health	If deceased, cause of death	Age at death
Father				
Mother				
Brother / Sister				
Husband / Wife				
Son / Daughter				

YOUR ALLERGIES:

Do you have a history of skin reaction or illness following oral administration or injection of.....?
 (Circle your response. Please specify the allergen if Yes is circled.)

- Penicillin or other antibiotics..... No ... Yes ... Don't know
- Morphine, Codeine, Demerol or other narcotics..... No ... Yes ... Don't know
- Novocaine or other anesthetics..... No ... Yes ... Don't know
- Sulfa drugs..... No ... Yes ... Don't know
- Tetanus Antitoxin or other serums..... No ... Yes ... Don't know
- Iodine or Merthiolate..... No ... Yes ... Don't know
- Any other drug or medication..... No ... Yes
- Aspirin or similar products..... No ... Yes
- Latex or adhesive tape..... No ... Yes
- Allergic to any foods (eggs, milk, chocolate)?..... No ... Yes ... List foods
- Allergic to any other substances?..... No ... Yes ... List substances

YOUR CURRENT MEDICATIONS:

What medications are you currently using? PLEASE LIST EVERYTHING.
 Include blood pressure medications, thyroid medications, tranquilizers, hormones, birth control pills, herbal compounds, vitamins, aspirin, Rogaine® (minoxidil), weight loss products, etc.

MEDICATION	DOSE.....	MEDICATION	DOSE.....

Have you taken Fen-Phen (fenfluramine phentermine)?..... No ... YesWhen?.....

Have you stopped using any medication in the past 6 months? No ... YesList medication(s) below.....

YOUR IMMUNIZATION HISTORY:

Have you received the basic immunization series for ... ? (Circle your response.)

- Influenza (THIS SEASON)..... No ... Yes
 - Diphtheria and Tetanus (DPT)..... No ... YesDate of last booster shot Mo. ____ Yr. ____
 - Polio..... No ... YesDate of last booster shot Mo. ____ Yr. ____
 - Meningitis..... No ... Yes
 - Pneumonia No ... Yes
 - Mumps No ... YesIgnore if you previously had the mumps
 - Rubella (German measles)..... No ... YesRubella immunization is necessary only if pregnancy is possible.
- Are you a Third World Traveler?..... No ... YesWhen & where was your last Third World trip?.....
- Typhoid Fever No ... YesDate of last immunization Mo. ____ Yr. ____
- Yellow fever No ... YesDate of last immunization Mo. ____ Yr. ____
- Hepatitis A No ... Yes2 shot series
- Hepatitis B..... No ... Yes3 shot series

YOUR PERSONAL SOCIAL HISTORY:

(If you choose to respond to the question, please circle your response.)

- What's your marital status? Single Married Separated Divorced Widowed
- Any previous marriages?..... No ... Yes How many previous marriages?.....
- Are you living with your spouse?..... No ... Yes
- Do you have dependents at home?..... No ... Yes Do you have a good relationship with your kids?..... No ... Yes
- How's your relationship?..... OK Significant problems No relationship at this time
- How's your sex life?..... OK Improvement needed None currently
- Are you retired? No ... Yes
- Are you employed?..... No ... YesOccupation
- Do you like your job?..... No ... Yes
- Do you have a high stress job?..... No ... Yes
- Are you often absent from work?..... No ... Yes About how many days per year?.....

SYSTEMIC REVIEW: Have you ever had? (Circle your response.)

No means you have NEVER had the condition.
Yes means you have had the condition at least ONCE in your life.
Now means you CURRENTLY have the condition or have RECENTLY (in past 6 months) had the condition.

GENERAL HEALTH

Good health most of your life?..... No ... Yes
Recent weight gain?..... No ... Yes
Unexpected recent weight loss?..... No ... Yes
Eat a well balanced diet?..... No ... Yes
Exercise regularly?..... No ... Yes
Dental exam in the past 6 mo.?..... No ... Yes
Yearly or bi-yearly eye exam by a MD Ophthalmologist?..... No ... Yes

HEAD

Glaucoma No ... Yes ... Now When were you last tested for glaucoma?... _____
Double vision No ... Yes ... Now Sore or irritated throat No ... Yes ... Now
Eye injury, disease..... No ... Yes ... Now Halitosis (persistent bad breath).... No ... Yes ... Now
Itchy eyes, allergies, runny nose..... No ... Yes ... Now Difficulty swallowing No ... Yes ... Now
Ear disease or infections..... No ... Yes ... Now Severe dizziness No ... Yes ... Now
Impaired hearing No ... Yes ... Now Loss of consciousness No ... Yes ... Now
Tinnitus (ringing in the ears)..... No ... Yes ... Now Change in normal adult voice No ... Yes ... Now
Sinus infections / sinus trouble No ... Yes ... Now Numbness or paralysis No ... Yes ... Now
Snoring / airway obstruction No ... Yes ... Now
Nosebleeds No ... Yes ... Now
Headaches No ... Yes ... Now Frequency?..... Seldom Often..... Daily
Intensity? Mild..... Moderate..... Severe

NECK

Stiff neck..... No ... Yes ... Now Neck injury No ... Yes ... Now
Sore lymph glands..... No ... Yes ... Now

RESPIRATORY

Upper respiratory infection..... No ... Yes ... Now Chronic or frequent cough No ... Yes ... Now
Coughing up blood / dark phlegm... No ... Yes ... Now Difficulty walking two blocks..... No ... Yes ... Now
Asthma or wheezing No ... Yes ... Now Night sweats No ... Yes ... Now
Pleurisy or Pneumonia No ... Yes ... Now Any lung problems No ... Yes ... Now
Fluid in the chest No ... Yes ... Now

Date of most recent Tuberculosis skin test..... _____ Were the results negative? No ... Yes
Date of most recent Chest X-ray, MRI or CAT..... _____ Were the results normal? No ... Yes
WOMEN: Date of most recent mammography..... _____ Were the results normal? No ... Yes

CARDIOVASCULAR

Shortness of breath (resting) No ... Yes ... Now Swollen hands, feet or ankles No ... Yes ... Now
Shortness of breath (walking) No ... Yes ... Now Rapid or skipped heartbeats No ... Yes ... Now
Chest pain or angina pectoris No ... Yes ... Now Heart murmur..... No ... Yes ... Now
Heart trouble..... No ... Yes ... Now Awaken during the night with the feeling you were smothering?..... No ... Yes ... Now
Date of most recent EKG..... _____ EKG results normal? No ... Yes

GASTROINTESTINAL

Intolerance to spices, coffee..... No ... Yes ... Now Cramping or abdominal pain No ... Yes ... Now
Intolerance to greasy foods No ... Yes ... Now Chronic constipation No ... Yes ... Now
Gallbladder trouble..... No ... Yes ... Now Frequent diarrhea No ... Yes ... Now
Heartburn or indigestion No ... Yes ... Now Change in bowel habits No ... Yes ... Now
Sour taste in mouth or throat No ... Yes ... Now Black stools No ... Yes ... Now
Peptic ulcer No ... Yes ... Now Painful bowel movements No ... Yes ... Now
Vomit frequently No ... Yes ... Now Rectal bleeding No ... Yes ... Now
Ever vomited blood? No ... Yes ... Now Hemorrhoids No ... Yes ... Now
Food stick in your throat No ... Yes ... Now Anal fissures No ... Yes ... Now
Liver trouble No ... Yes ... Now Back pain No ... Yes ... Now
Hepatitis..... No ... Yes ... Now Type?...A... B... C... Other When? _____
Date of most recent sigmoid / colonoscopy. _____ Were the results normal?..... No ... Yes

HEMATOLOGIC

Blood disease or blood disorder.... No ... Yes ... Now Anemic No ... Yes ... Now
Minor cuts slow to heal..... No ... Yes ... Now Abnormal bleeding or bruising..... No ... Yes ... Now
Phlebitis No ... Yes ... Now Bleeding excessively after surgery. No ... Yes

URINARY

Loss of urine when sneezing..... No ... Yes ... Now Frequent urination No ... Yes ... Now
Multiple night time urination No ... Yes ... Now Need to urinate immediately No ... Yes ... Now
Difficulty starting urination No ... Yes ... Now Loss of strength of urine stream No ... Yes ... Now
Bloody or dark colored urine..... No ... Yes ... Now Kidney stones No ... Yes ... Now
Solid particles in the urine No ... Yes ... Now Kidney or Bladder infection No ... Yes ... Now

SYSTEMIC REVIEW: Have you ever had? (Circle your response)

No means you have NEVER had the condition.
Yes means you have had the condition at least ONCE in your life.
Now means you CURRENTLY have the condition or have RECENTLY (in past 6 months) had the condition.

GENITAL - MEN

Venereal disease / herpes / warts... No ... Yes ... Now Prostate problems / pain No ... Yes ... Now
Testicular pain No ... Yes ... Now Unusual testicular lumps No ... Yes ... Now
Painful ejaculation No ... Yes ... Now Ejaculate at least twice a week..... No ... Yes
Date of last PSA test PSA results normal?..... No ... Yes

GYNECOLOGICAL - WOMEN

Venereal disease / herpes / warts.. No ... Yes ... Now Vaginal discharge..... No ... Yes ... Now
Pelvic Infection..... No ... Yes ... Now
Date of last PAP smear test PAP smear test results normal?..... No ... Yes

Menstrual periods began at _____ years of age.
Are you menopausal?..... No ... Yes Menopause occurred at _____ years of age.
Are periods regular and normal?.. No ... Yes Periods occur about every _____ days.....
Periods usually last about _____ days..... Date your most recent period began. _____
Number of pregnancies _____ Number of live deliveries _____

ENDOCRINE

Diabetes No ... Yes ... Now Intolerant to slightly cool rooms..... No ... Yes ... Now
Diabetes treatment / oral meds..... No ... Yes ... Now Intolerant to slightly warm rooms... No ... Yes ... Now
Diabetes treatment / insulin..... No ... Yes ... Now Change in skin or hair texture..... No ... Yes ... Now
Hormone therapy No ... Yes ... Now Crave large amounts of fluids..... No ... Yes ... Now
Pituitary disease No ... Yes ... Now Thyroid disease No ... Yes ... Now
As an adult, has your normal speaking voice changed?..... No ... Yes ... Now
As an adult, has your hat, glove or shoe size changed?..... No ... Yes ... Now

SKIN

Abnormal moles / pigmentation..... No ... Yes ... Now Hives, eczema or rash No ... Yes ... Now
Skin Disease No ... Yes ... Now Frequent infections or boils No ... Yes ... Now

LOCOMOTOR-MUSCULOSKELETAL

Varicose veins No ... Yes ... Now Weakness in muscles or joints..... No ... Yes ... Now
Difficulty walking No ... Yes ... Now Arthritis No ... Yes ... Now
Known joint disorders (i.e. partial tear in the knee meniscus) No ... Yes ... Now
Pain in calves or buttocks when walking, relieved by resting No ... Yes ... Now
Date of most recent bone density test Results within normal range?..... No ... Yes

NEUROLOGICAL AND PSYCHIATRIC

Fainting spells..... No ... Yes ... Now Often worry about your future..... No ... Yes ... Now
Temporary paralysis / convulsions.. No ... Yes ... Now Lack a goal or purpose in life No ... Yes ... Now
Anxious, nervous No ... Yes ... Now Absence of energy, usually tired ... No ... Yes ... Now
Trouble sleeping No ... Yes ... Now Ever advised to see a psychiatrist? No ... Yes ... Now
Depressed, dejected No ... Yes ... Now Ever had psychiatric care? No ... Yes ... Now
Loss of sex interest..... No ... Yes ... Now

CAFFEINE, TOBACCO, ALCOHOL & OTHER DRUG USE

Do you drink coffee or soda containing caffeine?..... No ... Yes.....How many cups or glasses per day? _____
Have you ever used tobacco products?..... No ... Yes ... Now.....Cigarettes...Cigars... Pipe ... Snuff... Chew
How many years have you used tobacco? _____
Do you drink alcoholic beverages?..... No ... Rarely ... 1 a week ... 1-2 a day ... 3-5 a day ... Over 5 a day
Have you abused alcohol now or in the past?..... No ... Yes ... Now
Do you currently use any recreational drugs?..... No ... Yes

AND FINALLY THE LAST QUESTION:

Do you have any other illness, symptom or disorder not mentioned in this questionnaire?.....No ... Yes Provide details below;

Source of information, if other than the patient: _____

Signature of person acquiring this information: _____

Patient's signature: _____ Date : _____