Patient Vital Intake Questionnaire

Please print this page, complete the form, and bring to your appointment

Name ______________________ **Cell Phone** ____________ **Work Phone** ____________

Birthdate (MM/DD/YYYY) _____________ **Age** ______ **Height** ______ **Weight** ______

Complaints and Treatment/Palliative Action (what makes it better):

____

____

List ALL surgeries/ trauma/ medications/ allergies (please provide dates, age, or year as best you can):

____

____

____

Family Medical History (check all that apply):

- ❏ obesity
- ❏ diabetes
- ❏ stroke
- ❏ heart disease
- ❏ seizures
- ❏ high blood pressure
- ❏ cancer
- ❏ other: ______________________________________

Your Habits:

- ❏ cigarettes
- ❏ street drugs (explain below) ______________________
- ❏ coffee (___ cups per day)
- ❏ tea (___ cups per day)
- ❏ bitter chocolate
- ❏ alcohol (___ drinks per week)
- ❏ sweet or milk chocolate
- ❏ sugar
- ❏ artificial sweeteners
- ❏ salt
- ❏ marijuana (❏ occasionally ❏ often)
- ❏ cola or carbonated beverages (___ cups per day)

Cravings:

____

Notes:

____

____

General:

- ❏ poor appetite
- ❏ insomnia
- ❏ cold hands
- ❏ fevers
- ❏ cravings
- ❏ sudden energy drops at (time)... ______________________
- ❏ strong thirst for.... ______________________
- ❏ heavy appetite
- ❏ fatigue
- ❏ cold feet
- ❏ chills
- ❏ localized weakness
- ❏ poor sleep
- ❏ tremors
- ❏ cold back
- ❏ night sweats
- ❏ poor coordination
- ❏ peculiar tastes and/or smells... ______________________
- ❏ bleed or bruise easily (where?) ______________________
- ❏ heavy sleep
- ❏ vertigo
- ❏ cold abdomen
- ❏ sweat easily
- ❏ change in appetite

(Please continue to pg. 2) →

PVIQ Cont. - Pg. 2

Please print this page, complete the form, and bring to your appointment

Skin and Hair:

- ❏ rashes
- ❏ eczema
- ❏ change in hair/skin texture
- ❏ ulcerations
- ❏ acne
- ❏ purpura
- ❏ hives
- ❏ dandruff
- ❏ itching
- ❏ loss of hair
- ❏ other: ____________________

Head, Eyes, Ears, Nose, and Throat:

- ❏ dizziness
- ❏ eye strain
- ❏ color blindness
- ❏ ringing in ears
- ❏ mucus
- ❏ teeth problems
- ❏ gum problems
- ❏ sores on lips or tongue
- ❏ recurrent sore throats
- ❏ night blindness
- ❏ sinus problems
- ❏ concussions
- ❏ eye pain
- ❏ cataracts
- ❏ poor hearing
- ❏ dry throat
- ❏ jaw clicks
- ❏ spots in eyes
- ❏ grinding teeth
- ❏ facial pain
- ❏ glasses
- ❏ earaches
- ❏ headaches (location and frequency) ____________________
- ❏ migraines (location and frequency) ____________________
- ❏ poor vision
- ❏ blurry vision
- ❏ nose bleeds
- ❏ dry mouth
- ❏ copious saliva

Cardiovascular:

- ❏ high blood pressure
- ❏ dizziness
- ❏ irregular heartbeat
- ❏ low blood pressure
- ❏ fainting
- ❏ phlebitis
- ❏ chest pain
- ❏ blood clots
- ❏ swelling in the hands and/or feet
- ❏ cold hands and/or feet
- ❏ difficulty breathing
- ❏ other: ____________________

Respiratory:

- ❏ cough
- ❏ pneumonia
- ❏ production of phlegm
  color: ____________
- ❏ coughing blood
- ❏ asthma
- ❏ bronchitis
- ❏ tight chest
- ❏ difficulty breathing when lying down

Gastrointestinal:

- ❏ nausea
- ❏ gas
- ❏ bad breath
- ❏ constipation
- ❏ pain or cramps
- ❏ vomiting
- ❏ belching
- ❏ rectal pain
- ❏ bloody stools
- ❏ diarrheas
- ❏ black stool
- ❏ hemorrhoids
- ❏ sensitive abdomen
- ❏ laxative use:
  ________ /per wk.
  type: ____________
- ❏ bowel movement:
  frequency ____________
  color ____________
  odor ____________
  texture/form ____________

(Please continue to pg. 3) ⟶

PVIQ Cont. - Pg. 3

Please print this page, complete the form, and bring to your appointment

Genito-Urinary:

❏ pain on urination ❏ frequent urination ❏ blood in urine ❏ urgency to urinate
❏ unable to hold urine ❏ kidney stones ❏ venereal disease ❏ impotency
❏ wake up to urinate how often: ______ /night time: ______ ❏ other ____________________

Pregnancy and Gynecology:

❏ vaginal discharge
❏ clots
❏ vaginal sores
❏ breast lumps
❏ changes in body/psyche prior to menstruation
❏ premature births
❏ miscarriages
❏ irregular periods

❏ number of pregnancies ____________________
❏ age of first period ____________________
❏ last period (date & duration) ____________________
❏ menopause (date) ____________________
❏ last PAP (date) ____________________
❏ birth control (type) ____________________

Musculoskeletal:

❏ neck pain ❏ back pain ____________________ ❏ joint pain ____________________
❏ muscle pain ❏ other ____

Neuropsychological:

❏ seizures ❏ anxiety ❏ concussion
❏ depression ❏ poor memory ❏ easily stressed
❏ areas of numbness ❏ bad temper ❏ considered/attempted suicide
❏ treated for emotional problems ❏ other ____________________