PLEASE BRING THIS COMPLETED FORM TO YOUR APPOINTMENT

KENNETH R. KAFKA, MD
Patient Questionnaire

Name _____ Date _____
Referred by? _____

What are your current symptoms and complaints?
1.
2.
3.
4.

PAST MEDICAL HISTORY: Please list significant medical problems (by decade) of your life:
Childhood illnesses:

Adolescence:

Twenties:

Thirties:

Forties:

Fifties:

Sixties plus:

PAST SURGICAL HISTORY: in chronological order including approximate year:
1.
2.
3.
4.
5.
6.

MEDICATIONS and HORMONES: dosages and how often you take them:
1.
2.
3.
4.
5.
6.
7.
8.

SUPPLEMENTS: herbs, vitamins etc. and dosages:
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

ALLERGIES:

HABITS:
Do you or have you smoked cigarettes, cigars? If so, how much and for how many years?

Alcohol: Type and frequency

Exercise: Type(s) and frequency

Caffeine: Type(s) and frequency

How much water do you drink each day?

What are the top two STRESSORS in your life?
1.
2.

What is your greatest fear?

Do you have SPIRITUAL life? If so, how would you describe it?

SOCIAL HISTORY:
Where were you born and where did you grow up?

Do you live alone?

Any pets?

Marriage(s):

Occupation(s):

Children and their ages:

REVIEW OF SYSTEMS:
Do you currently have or have you ever had any of the following symptoms to a significant degree? (Mark each item with either Y or N. If Y, please explain.)
Headaches:
Post-nasal drip?
Chronic dental problems:
Shortness of breath:
Chest pains:
Chronic cough:
Do you have regular bowel movements?
Gas and or bloating:
Heartburn:
Diarrhea:
Constipation:
Is your sex drive satisfactory? (explain)
Frequent urination:
Urination at night:
Sugar cravings:
Interrupted sleep: (explain)
Insomnia (Explain):
Do you feel rested when you wake up?
Anxiety:
Depression:
Mood swings:
Irritability:
Night Sweats:
Fatigue (explain):
OTHER:

DIET:
Describe as specifically as possible a typical
Breakfast:

Lunch:

Dinner:

Snack(s):
Are you hungry before bedtime?

WOMEN: Approximate date of last:
Pap smear: Thermogram:
Mammogram: Sonogram

MEN:
Prostate problems
Satisfactory erections?
Any problems with urination?

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FAMILY HISTORY:

Family Member	Age if Living?	Age at Death	Cause of Death	Other medical conditions *
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Brother(s)				
Brother(s)				
Brother(s)				
Sisters(s)				
Sisters(s)				
Sisters(s)				

*Medical conditions of genetic significance such as cancer, diabetes, heart trouble, hypertension, stroke, nervous disorder, alcoholism, blood disease, arrhythmias, etc.