Dr. Walton's Questionnaire

The following information is confidential and will be released with your signed permission.

Please fill out the following information as completely as possible. If you do not understand a question, please ask a staff member for help.

Name:_____ Date: _____

List hospitalizations and the reason: _____

_____

_____

List all surgeries: _____

_____

_____

List allergies: _____

List medications presently taking: _____

_____

_____

_____

Circle any of the following illnesses you have been diagnosed as having:

Diabetes Cancer Thyroid disease

Circle the correct answer

Have you ever had a heart attack?	Yes	No
Have you ever had or been treated for angina pectoris?	Yes	No
Have you ever been treated for high blood pressure?	Yes	No
Have you had the onset of chest pain and/or shortness of breath within the past six months?	Yes	No
Have you ever had or been treated for irregular heart beats?	Yes	No
Have you ever had or been treated of swelling of the feet or legs?	Yes	No
Are you frequently awakened at night be shortness of breath?	Yes	No
Have you ever had or been treated for rheumatic heart disease?	Yes	No
Have you ever been treated for pneumonia?	Yes	No
Have you ever coughed up blood?	Yes	No

Have you ever had or been treated for emphysema?	Yes	No
Have you ever had or been treated for asthma?	Yes	No
Have you ever had or been treated for blood clot(s) to the lungs?	Yes	No

Have you ever had or been treated for a hernia?	Yes	No
Have you ever had or been treated for stomach ulcers?	Yes	No
Have you ever vomited blood?	Yes	No
Have you ever had mucous or bloody diarrhea?	Yes	No
Do you regularly have constipation?	Yes	No
Do you regularly have diarrhea?	Yes	No
Have you ever had or been treated for colitis?	Yes	No

Have you ever had or been treated for seizures?	Yes	No
Have you ever had or been treated for a stroke?	Yes	No
Have you ever had or been treated for loss of consciousness?	Yes	No
Have you ever had or been treated for double vision?	Yes	No
Have you ever had problems with blurred vision?	Yes	No
Have you ever been treated for any other visual problems?	Yes	No
Have you ever been treated for depression?	Yes	No
Have you ever been treated for any other psychiatric illness?	Yes	No
Have you ever had psychiatric counseling or treatment?	Yes	No
Have you recently had to onset of headaches?	Yes	No
Have you ever had any paralysis?	Yes	No
Do you now or have you ever had any areas of numbness?	Yes	No

Have you ever had or been treated for arthritis?	Yes	No
Have you ever had or been treated for rheumatoid arthritis?	Yes	No
Have you ever had any other disease of the bones or joints?	Yes	No
Have you ever had or been treated for swelling of the joints?	Yes	No
Have you ever had or been treated for gout?	Yes	No
Have you ever had or been treated for kidney or bladder infections?	Yes	No

Have you ever had or been treated for kidney stones?	Yes	No
Have you ever had or been treated for blood in the urine?	Yes	No
Have you ever had or been treated for other disease of the kidneys?	Yes	No

Men Only

Have you ever had or been treated for prostate gland infection?	Yes	No
Have you ever had or been treated for swelling of the testicles?	Yes	No
Have you ever had or been treated for infection of the testicles?	Yes	No
Have you ever had or been treated for infection of the penis?	Yes	No

Women Only

What was the date of your last menstrual period?		
How many times have you been pregnant?		
How many living children f you have?		
How many miscarriages have you had?		
What was the date of your last pap smear?		
Have you ever had or been treated for pelvic or female infection?	Yes	No
Have you ever had or been treated for cyst of the ovary?	Yes	No
Have you ever had or ben treated for disease of the uterus (womb)?	Yes	No
Have you ever had or been treated for infection of the vagina?	Yes	No