RYON MEDICAL & ASSOCIATES, LLC.
P.O. Box 497
318 Lacey Ave
La Junta, Colorado 81050
719-384-0303 (Phone) ~ 719-384-1033 (Fax)

MEDICAL HISTORY QUESTIONNAIR

Patient Name: _____ Date: _____

Since this is your medical history and it will be used in evaluating your health, it is extremely important that the questions be answered as accurately and completely as possible. All information provided is kept confidential.

PRESENT ILLNESS

PRESENT MEDICAL PROBLEMS

Please list any known medical problems that you have at present.

MEDICAL PROBLEM	DATE OF ONSET	COMMENTS

CURRENT MEDICATIONS

Please list all medications that you are currently taking (including insulin, oral contraceptives, over-the-counter medications, vitamins, diet supplements, herbal preparations, etc.).

MEDICATION	TAKEN FOR	DOSAGE	DOSES PER DAY	DATE STARTED

MEDICATION ALLERGIES

Please list all medication/substances that you have an allergy to and what your reaction to that allergen is (please include not only prescription and over the counter medications but also things such as latex, plastic tape, etc.)

MEDICATION	REACTION

PAST MEDICAL HISTORY

SIGNIFICANT PAST ILLNESS

Please list any other illnesses you have had as a child or adult.

ILLNESS	YEAR(S)	COMMENTS

PAST SURGERY

Please list in chronological order any surgeries (hospital and outpatient) that you have had.

TYPE OF SURGERY	YEAR(S)	COMMENTS

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________________________________ ______ ________________________________

________________________________ ______ ________________________________

________________________________ ______ ________________________________

IMMUNIZATIONS

1. When was your last tetanus shot? ___/___/___
2. Do you have an annual flu vaccine? _____Yes _____ No
3. Have you had a pneumococcal vaccine (Pneumovax)? _____ Yes _____No
4. Have you had a tuberculosis skin test (PPD or Tine)? ____ Yes ____ No Date ___/___/_____ Negative? _____ Positive

FAMILY MEDICAL HISTORY

PARENTS

1. Are you adopted and/or unaware of your biological parents' medical history? _____Yes _____No

(If yes, please move on to the BROTHERS AND SISTERS section.)

Please complete the following information, if you parents' medical history is known.

	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH	MAJOR HEALTH PROBLEMS (Mark all that apply.)
Father	___________	____________	_______________	_____Cancer _____Diabetes _____Stroke _____Heart Attack/M.I. _____Hypertension _____ Other (Specify): __________________________
Mother	___________	____________	_______________	_____Cancer _____Diabetes _____Stroke _____Heart Attack/M.I. _____Hypertension _____ Other (Specify): __________________________

BROTHERS AND SISTERS

1. Are you adopted and/or unaware of your biological siblings' medical history? _____Yes _____No

(If yes, please skip ahead to the CHILDREN section.)

Please complete the following information for each of your siblings, if their medical history is known.

SEX	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH	MAJOR HEALTH PROBLEMS (Mark all that apply.)
M F	___________	____________	_______________	_____Cancer _____Diabetes _____Stroke _____Heart Attack/M.I. _____Hypertension _____ Other (Specify): __________________________
M F	___________	____________	_______________	_____Cancer _____Diabetes _____Stroke _____Heart Attack/M.I. _____Hypertension _____ Other (Specify): __________________________
M F	___________	____________	_______________	_____Cancer _____Diabetes _____Stroke _____Heart Attack/M.I. _____Hypertension _____ Other (Specify): __________________________
M F	___________	____________	_______________	_____Cancer _____Diabetes _____Stroke _____Heart Attack/M.I. _____Hypertension _____ Other (Specify): __________________________
M F	___________	____________	_______________	_____Cancer _____Diabetes _____Stroke _____Heart Attack/M.I. _____Hypertension _____ Other (Specify): __________________________

_____Cancer _____Diabetes _____Stroke

CHILDREN

1. Do you have any biological children? _____Yes _____No

(If no, please skip ahead to the REVIEW OF SYSTEMS section.)

Please complete the following information for each of your children, if their medical history is known.AGE

SEX AGE (LIVING) AGE (AT DEATH) CAUSE OF DEATH MAJOR HEALTH PROBLEMS

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M F _____ _____ _____ _____Cancer _____Diabetes _____Stroke _____Heart Attack/M.I. _____Hypertension _____ Other (Specify): _____

M F _____ _____ _____ _____Cancer _____Diabetes _____Stroke _____Heart Attack/M.I. _____Hypertension _____ Other (Specify): _____

M F _____ _____ _____ _____Cancer _____Diabetes _____Stroke _____Heart Attack/M.I. _____Hypertension _____ Other (Specify): _____

M F _____ _____ _____ _____Cancer _____Diabetes _____Stroke _____Heart Attack/M.I. _____Hypertension

SOCIAL/LIFESTYLE HISTORY

PERSONAL INFORMATION

City of Birth: _____
Number of children? _____
You are not required to answer the following questions; however, the answers may help your physician provide you with better advice and treatment.
Do you have a specific religion? Yes _____ (Specify): _____ No _____
Do you find your sexual life to be satisfactory? _____Yes _____No
What is your sexual preference? _____Heterosexual _____Homosexual _____Bisexual
Do you have more than one sexual partner per year? _____Yes _____No

PERSONAL HABITS

TOBACCO:
1. Do you live with people who smoke? Yes No
2. Did your parents smoke when you were growing up? Yes ⇳ No
3. Have you ever used tobacco? Yes No (If No, skip to ALCOHOL section.)
4. Do you currently use tobacco? Yes No (If No, skip to question 5.)
   If you smoke cigarettes, how many per day? What year did you start?
   If you smoke cigars, how many per day? What year did you start?
   If you smoke a pipe, how many pipefuls per day? What year did you start?
   If you use "smokeless" tobacco, how many times per day? What year did you start?

ALCOHOL:

1. Do you drink alcoholic beverages? _____Yes _____No
If yes, please identify which of the following you consume.
How many per week?
Beer (12 oz.) _____
Wine (6 oz.) _____
Liquor (1.5 oz.) _____
2. Have you used alcohol in the past but subsequently quit? _____Yes _____No
3. Do you now have or have you ever had problems with excessive alcohol use? _____Yes _____No

ILLICIT/RECREATIONAL DRUGS:
1. Do you now or have you ever used illicit/recreational drugs? _____Yes _____No

Comments: _____

PHYSICAL EXERCISE

1. How do you rate your current level of physical activity compared to others of your same age and sex?
(Think about both leisure and work activities.)
_____Extremely Inactive _____Inactive _____Somewhat Inactive _____Extremely Active _____Active _____

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Somewhat Active _____About Average

2. Compared to a year ago, how much regular exercise do you currently get?
_____Much Less _____Somewhat Less _____About the Same _____Somewhat More _____Much More

3. Are you currently involved in a regular exercise program? _____Yes _____No

4. How often do you exercise?
____Never _____Rarely _____Once a week _____Several times a week _____Daily

What types of exercises? _____

DIAGNOSTIC STUDIES

Mark all of the diagnostic studies you have had performed, and enter a four digit year.

TEST	YEAR		COMMENTS
EKG or ECG (Electrocardiogram)	_____		_____
Treadmill or Exercise Stress Test	_____		_____
Chest X-ray	_____		_____
Please include Year/Month for below:		Month	
Bone Densitometry	_____	_____	_____
Sigmoidoscopy or Colonoscopy	_____	_____	_____
Mammogram	_____	_____	_____
Pelvic Exam/Pap Smear	_____	_____	_____

REVIEW OF SYSTEMS

Please indicate whether you have ever had a significant problem with any of the symptoms or conditions listed below.

GENERAL	YES	NO	DON'T KNOW	IF YES, YEAR OF ONSET?	IS THIS STILL A PROBLEM?	COMMENTS
1. Unexplained weight loss	_____	_____	_____	_____	_____Yes _____No	_____
What was the magnitude of this weight loss? _____0-5 lbs. _____5-15 lbs. _____15-25 lbs. _____>25lbs.						
2. Unexplained weight gain	_____	_____	_____	_____	_____Yes _____No	_____
What was the magnitude of this weight gain? _____0-5 lbs. _____5-15 lbs. _____15-25 lbs. _____>25lbs.						
3. Chronic fatigue	_____	_____	_____	_____	_____Yes _____No	_____
4. Change in appetite	_____	_____	_____	_____	_____Yes _____No	_____
5. Night Sweats	_____	_____	_____	_____	_____Yes _____No	_____
6. Fever or chills	_____	_____	_____	_____	_____Yes _____No	_____
7. Any type of cancer	_____	_____	_____	_____	_____Yes _____No	_____

HEART/VASCULAR	YES	NO	DON'T KNOW	IF YES, YEAR OF ONSET?	IS THIS STILL A PROBLEM?	COMMENTS
8. Chest pain or pressure	_____	_____	_____	_____	_____Yes _____No	_____
9. Chest pain with exertion	_____	_____	_____	_____	_____Yes _____No	_____
10. Heart Attack	_____	_____	_____	_____	_____Yes _____No	_____
11. Rapid/Irregular heartbeats	_____	_____	_____	_____	_____Yes _____No	_____

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12. Fainting/Lightheadedness	_____	_____	_____	_____	_____Yes	_____No	_____
13. High blood pressure	_____	_____	_____	_____	_____Yes	_____No	_____
14. Rheumatic fever	_____	_____	_____	_____	_____Yes	_____No	_____
15. Calf pain with exercise	_____	_____	_____	_____	_____Yes	_____No	_____
16. Varicose veins	_____	_____	_____	_____	_____Yes	_____No	_____
17. Phlebitis	_____	_____	_____	_____	_____Yes	_____No	_____
18. Stroke	_____	_____	_____	_____	_____Yes	_____No	_____
19. High blood cholesterol	_____	_____	_____	_____	_____Yes	_____No	_____
20. High blood triglycerides	_____	_____	_____	_____	_____Yes	_____No	_____

EYES

21. Decrease in vision	_____	_____	_____	_____	_____Yes	_____No	_____
Date of last eye exam? ___/___/___							
22. Double vision	_____	_____	_____	_____	_____Yes	_____No	_____
23. Glaucoma	_____	_____	_____	_____	_____Yes	_____No	_____
24. Color blindness	_____	_____	_____	_____	_____Yes	_____No	_____
25. Cataracts	_____	_____	_____	_____	_____Yes	_____No	_____
26. Serious injury to eye	_____	_____	_____	_____	_____Yes	_____No	_____

EAR-NOSE-THROAT

27. Hearing loss	_____	_____	_____	_____	_____Yes	_____No	_____
28. Prolonged exposure to loud noise	_____	_____	_____	_____	_____Yes	_____No	_____
29. Ringing in ears	_____	_____	_____	_____	_____Yes	_____No	_____
30. Chronic ear infections	_____	_____	_____	_____	_____Yes	_____No	_____
31. Ruptured eardrum	_____	_____	_____	_____	_____Yes	_____No	_____
32. Snoring	_____	_____	_____	_____	_____Yes	_____No	_____
33. Sinus infection	_____	_____	_____	_____	_____Yes	_____No	_____
34. Allergy related nasal congestion	_____	_____	_____	_____	_____Yes	_____No	_____

BONE AND JOINT

35. Chronic joint and muscle pain	_____	_____	_____	_____	_____Yes	_____No	_____
36. Low back pain	_____	_____	_____	_____	_____Yes	_____No	_____
37. Swollen/stiff joints	_____	_____	_____	_____	_____Yes	_____No	_____
38. Arthritis	_____	_____	_____	_____	_____Yes	_____No	_____
39. Gout	_____	_____	_____	_____	_____Yes	_____No	_____

ENDOCRINE	YES	NO	DON'T KNOW	IF YES, YEAR OF ONSET?	IS THIS STILL A PROBLEM?		COMMENTS
40. Thyroid disease	_____	_____	_____	_____	_____Yes	_____No	_____
41. High blood sugar	_____	_____	_____	_____	_____Yes	_____No	_____
42. Diabetes	_____	_____	_____	_____	_____Yes	_____No	_____
PULMONARY							
43. Chronic cough or phlegm	_____	_____	_____	_____	_____Yes	_____No	_____
44. Wheezing	_____	_____	_____	_____	_____Yes	_____No	_____

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45. Asthma _____ _____ _____ _____ _____Yes _____No _____
46. Tuberculosis _____ _____ _____ _____ _____Yes _____No _____
47. Bronchitis _____ _____ _____ _____ _____Yes _____No _____
48. Pneumonia _____ _____ _____ _____ _____Yes _____No _____
49. Emphysema _____ _____ _____ _____ _____Yes _____No _____
50. Coughed up blood _____ _____ _____ _____ _____Yes _____No _____
51. Shortness of breath _____ _____ _____ _____ _____Yes _____No _____

GASTROINTESTINAL

52. Fatty food intolerance _____ _____ _____ _____ _____Yes _____No _____
53. Ulcer disease _____ _____ _____ _____ _____Yes _____No _____
54. Frequent heartburn _____ _____ _____ _____ _____Yes _____No _____
55. Vomited blood _____ _____ _____ _____ _____Yes _____No _____
56. Gallbladder trouble _____ _____ _____ _____ _____Yes _____No _____
57. Abdominal pain _____ _____ _____ _____ _____Yes _____No _____
58. Jaundice, hepatitis, or cirrhosis _____ _____ _____ _____ _____Yes _____No _____
59. Frequent diarrhea _____ _____ _____ _____ _____Yes _____No _____
60. Diarrhea caused by milk / lactose intolerance _____ _____ _____ _____ _____Yes _____No _____
61. Blood in stool _____ _____ _____ _____ _____Yes _____No _____
62. Black stool _____ _____ _____ _____ _____Yes _____No _____
63. Hemorrhoids _____ _____ _____ _____ _____Yes _____No _____
64. Colon polyps _____ _____ _____ _____ _____Yes _____No _____
65. Chronic constipation _____ _____ _____ _____ _____Yes _____No _____

NEUROPSYCHIATRY

66. Loss of consciousness _____ _____ _____ _____ _____Yes _____No _____
67. Vertigo _____ _____ _____ _____ _____Yes _____No _____
68. Memory Problems _____ _____ _____ _____ _____Yes _____No _____
69. Seizures or epilepsy _____ _____ _____ _____ _____Yes _____No _____
70. Frequent headaches _____ _____ _____ _____ _____Yes _____No _____
71. Numbness or tingling of arms, legs, or face _____ _____ _____ _____ _____Yes _____No _____
72. Difficulty sleeping _____ _____ _____ _____ _____Yes _____No _____
73. Depression _____ _____ _____ _____ _____Yes _____No _____
74. Anxiety _____ _____ _____ _____ _____Yes _____No _____

NEUROPSYCHIATRY (Cont.)

75. Thoughts of suicide _____ _____ _____ _____ _____Yes _____No _____
76. Nervous breakdown _____ _____ _____ _____ _____Yes _____No _____
77. Psychiatric or psycho _____ _____ _____ _____ _____Yes _____No _____
Logical counseling _____ _____ _____ _____ _____Yes _____No _____

HEMATOLOGY

78. Anemia _____ _____ _____ _____ _____Yes _____No _____
79. Bleeding disorder _____ _____ _____ _____ _____Yes _____No _____
80. Previous blood transfusion _____ _____ _____ _____ _____Yes _____No _____
81. Enlarged or swollen lymph nodes _____ _____ _____ _____ _____Yes _____No _____

DERMATOLOGY

82. Skin rash _____ _____ _____ _____ _____Yes _____No _____
83. Skin cancer _____ _____ _____ _____ _____Yes _____No _____
84. Shingles/herpes zoster _____ _____ _____ _____ _____Yes _____No _____
85. Skin sores that won't heal _____ _____ _____ _____ _____Yes _____No _____
86. Unusual moles _____ _____ _____ _____ _____Yes _____No _____

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87. Mouth sores that won't heal _____ _____ _____ _____ _____Yes _____No _____
88. Skin or toenail fungus _____ _____ _____ _____ _____Yes _____No _____
89. Psoriasis _____ _____ _____ _____ _____Yes _____No _____
90. Other _____ _____ _____ _____ _____Yes _____No _____

GENITOURINARY

91. Sexually transmitted disease
    - -syphilis _____ _____ _____ _____ _____Yes _____No _____
    - - gonorrhea _____ _____ _____ _____ _____Yes _____No _____
    - - herpes _____ _____ _____ _____ _____Yes _____No _____
    - - other _____ _____ _____ _____ _____Yes _____No _____
92. HIV positive/AIDS _____ _____ _____ _____ _____Yes _____No _____
93. Blood in urine _____ _____ _____ _____ _____Yes _____No _____
94. Burning or pain during urination _____ _____ _____ _____ _____Yes _____No _____
95. Kidney/bladder infection _____ _____ _____ _____ _____Yes _____No _____
96. Kidney stones _____ _____ _____ _____ _____Yes _____No _____

Questions 97-100: Male-specific

97. Impotence/Erectile dysfunction _____ _____ _____ _____ _____Yes _____No _____
98. Difficulty urinating (starting or stopping) _____ _____ _____ _____ _____Yes _____No _____
99. Awakening to urinate _____ _____ _____ _____ _____Yes _____No _____
100. Prostate trouble _____ _____ _____ _____ _____Yes _____No _____

Questions 101-107: Female-specific

101. Sexual Problems _____ _____ _____ _____ _____Yes _____No _____
    (ex. pain with intercourse)
    If yes, please comment: _____
102. How many times have you been pregnant? _____
103. Number of miscarriages or abortions: _____
104. When did your last menstrual period begin? _____
105. How long do your periods typically last? _____
106. How often do they occur? _____
107. Do you have any problems related to your periods? _____ _____ _____ _____ _____Yes _____No_____
    If yes, please comment: _____

Thank you for your time and patience in completing this questionnaire. If you have any questions or concerns, please call us at 719-384-0303.