SARAH RETTINGER, MD AT PROVIDENCE SAINT JOHN'S HEALTH CENTER

PATIENT QUESTIONNAIRE

Name: _____ **Date:** _____

Your phone numbers: *Home* _____ *Cell:* _____ **E-Mail address:** _____

Emergency contact person: _____ *Phone number:* _____

I came to see Dr. Rettinger by: ___ **Referral from another physician (name):** _____

___ **Referral from a friend or another patient (name):** _____

___ **My own research (explain):** _____

___ **Other:** _____

Why are you seeing Dr. Rettinger?

_____

What are your symptoms related to this problem?

1. _____ **3.** _____

2. _____ **4.** _____

Have you been diagnosed with other medical problems?

High blood pressure _____ Heart disease (Heart attack): _____

High Cholesterol/ Hyperlipidemia _____ Diabetes _____

Lung disease/Asthma _____ Thyroid problems _____

Gastro-intestinal problems _____ Kidney disease/Dialysis _____

Depression _____ Calcium disorder _____

Seizures _____ Stroke _____

Cancer – type? _____ Polycystic Ovasries: _____

Other issues: _____

Please list any past surgeries and the year performed:

1. _____
2. _____
3. _____

Which doctors need a copy of today's consultation note from Dr. Rettinger? Please provide phone and fax numbers.

1. _____ **3.** _____

2. _____ **4.** _____

2121 Santa Monica Boulevard, Santa Monica, CA 90404*Phone 310.829.8751*Fax 310.315.6113

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MEDICATIONS

Are you taking any medications? Y N If YES please list below:

1._____ 4._____
2._____ 5._____
3._____ 6._____

ALLERGIES: Do you have any allergies to medications? Y N
If YES please list below and describe reaction to medication:

1. _____
2. _____
3. _____
4. _____

SOCIAL HISTORY

Married _____ Single _____ Children? _____ Number: _____
Are you currently employed? _____ Current position? _____
Are you disabled? _____How long? _____
Do you drink alcohol? _____ If yes, how often? _____ Do you smoke? _____ If yes, how often? _____

FAMILY HEALTH HISTORY

Has anyone in your immediate family (siblings, parents, children) experienced any of the following conditions? Indicate their relationship to you in the space next to the box:

Heart disease (Heart attack)_____ High blood pressure _____

Lung disease/Asthma _____ Kidney disease/Dialysis _____

Diabetes _____ Thyroid problems _____

Depression_____ Pituitary disease _____

Seizures_____ Stroke_____

Cancer – type?_____ Other issue:_____

REVIEW OF SYSTEMS: Please indicate any of the following symptoms you are experiencing:

General

Y N Don't Know

___Fever, chills, sweats
___Loss of appetite, weight loss

Eyes

___ Eye irritation/ infection
___ Glaucoma/ cataract/ eye surgery
___ Wear glasses/ contacts

Gastrointestinal

Y N Don't Know

___ Nausea/ vomiting
___ Diarrhea/ constipation/ bloody stools
___ Heartburn/ indigestion/reflux disease
___ Polyps/colonoscopy

Genitourinary

___ Increased urination

___ Difficulty urinating, blood in urine

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ENT/ Mouth
___ Earache/ ringing
___ Sinusitis, runny nose, allergies
___ Trouble swallowing/Hoarsness

Respiratory
___Asthma, emphysema/bronchitis
___ Cough
___ Recent chest x-ray
___ Tuberculosis

Cardiovascular
___ Short of breath
___ Irregular heart beat
___ Irregular periods

Psychiatric
___ Depression
___ Anxiety disorder

Musculoskeletal
___ Leg cramps
___ Arthritis/ arthralgias/ gout
___ Soft tissue/ bony trauma
___ Tremor

Skin
___ Leg ulcers/ discoloration of feet/legs
___ Bruising/ bleeding tendencies
___ Acne
___ Increased facial/body hair

Reproductive
___ Normal periods
___ Absent periods

___ Post-menopausal
___ Pre-menopausal
___ Hysterectomy

Please sign below:

Patient Signature:_____

Affix Patient Label Here

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