JEFFREY SIMON MD
ADDICTION MEDICINE & PSYCHIATRY
1930 Marlton Pike East, Suites U 99 & U 100 • Cherry Hill, NJ 08034
Phone: 856-888-1326 Fax: 856-281-9898

INITIAL HISTORY QUESTIONNAIRE

Date: _____

Name: _____ Date of Visit: _____

We ask that you take time to complete this questionnaire to the best of your knowledge. This questionnaire will allow the doctor to get to know more about you, your medical condition, your family and your life experiences. The questionnaire is confidential and will be kept as part of your medical records.

REFERRING PHYSICIAN INFORMATION:

NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

SPECIALTY: _____

If you were not referred by a physician, who referred you? _____

Is your appointment associated with any legal or potential legal activity? _____

If so, please elaborate: _____

_____

HISTORY OF PRESENT ILLNESS:

Briefly describe the reason for your visit: _____

_____

_____

1. What symptoms are you experiencing, if any? _____

2. How severe is the problem? _____

3. How long have you had the problem? _____

4. Have you obtained prior treatment? _____

5. Have you experienced similar symptoms or had a similar problem in the past? _____

6. Does anything help make the problem go away? _____
   If so, what? _____

7. With whom and for how long? _____

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REVIEW OF SYSTEMS

Please circle and provide a brief detail below for the medical conditions below which apply to you whether past or present.

CONSTITUTIONAL
_ Weight loss or gain
_ Change in appetite
_ Altered taste or smell
_ Excessive sleepiness
_ Unable to sleep
_ Fatigue
_ Fever

CARDO-VASCULAR
_ Chest pain/pressure
_ Angina
_ Leg swelling
_ High blood pressure
_ Low blood pressure
_ Shortness of breath

INTEGUMENTARY
_ Skin rash
_ Hives
_ Itching

GENITOURINARY
_ Painful urination
_ Blood in urine
_ Frequent urination
_ Urinary urgency
_ Urinary incontinence
_ Impotence
_ Sexual dysfunction
_ Venereal disease
_ Vaginal disease
_ Changes in libido
_ Sexual concerns

ALLERGY/IMM
_ Allergies-Food
_ Allergies-Drug (Specify below)

EYES
_ Blurred vision
_ Double vision
_ Glaucoma
_ Cataracts

EAR,NOSE,MOUTH,THROAT
_ Hearing loss/Ringing in ears
_ Dizziness
_ Nose bleeds/discharge
_ Trouble breathing through nose
_ Sinus disease
_ Mouth sores
_ Sore throat
_ Trouble swallowing

HEMO-LYMPHATIC
_ Blood disorder
_ Enlarged lymph nodes

PSYCHOLOGICAL
_ Depression
_ Anxiety
_ Trouble concentrating
_ Confusion
_ Fears
_ Self-destructive behavior
_ Racing thoughts
_ Abnormal thoughts

MUSCULOSKELETAL
_ Low back pain
_ Neck pain
_ Joint pain
_ Joint swelling
_ Muscle spams

RESPIRATORY
_ Emphysema
_ Chronic cough
_ Tuberculosis
_ Difficulty Breathing

GASTROINTESTINAL
_ Diarrhea
_ Rectal bleeding
_ Hepatitis
_ Abdominal pain
_ Vomiting
_ Constipation

ENDOCRINE
_ Diabetes
_ Thyroid disease
_ Breast disease
_ Male/Female Endocrine problems

NEUROLOGIAL
_ Headache
_ Seizures
_ Loss of consciousness
_ Memory loss
_ Weakness/Numbness
_ Tingling
_ Trouble Walking
_ Trouble with balance
_ Vertigo

_ **AIDS/HIV**

ALLERGIES (Specify): _____

RECREATIONAL DRUG USE (Specify): _____

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Please list **ALL CURRENT MEDICATIONS** you are taking (including over the counter drugs, vitamins and supplements), with dosage and times at which they are taken.

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

PAST MEDICAL HISTORY

Please indicate all medical and/or medical and/or psychiatric hospitalizations you have had in the past, with approximate dates and reason for admission: _____

_____

_____

Please list **ALL CURRENT MEDICAL PROBLEMS**, as well as major illnesses you have had in the past with approximate dates: _____

_____

_____

FAMILY HISTORY

Please list all the medical and psychological problems and current ages of the following family members. If they are deceased, please list cause and approximate age of death.

GRANDPARENTS:
1. _____
2. _____
3. _____
4. _____

MOTHER: _____

FATHER: _____

BROTHER(S): (List name, age, occupation, brief history): _____

_____

_____

SISTERS(S): (List name, age, occupation, brief history): _____

_____

_____

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CHILDREN: (List name, age, occupation, brief history): _____

_____

_____

SOCIAL HISTORY

Please check your highest level of education:

☐ Grade School ☐ High School ☐ College/Vocational ☐ Graduate

Where do you work? (If retired or unemployed, list the most recent place of employment and last date of work):

_____

_____

What was your position there? _____

Please check: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Have You been married more than once? ☐ Yes ☐ No

Spouse's occupation (if applicable): _____

Current living arrangements: _____

Hobbies: _____

Do you smoke? ☐ Yes ☐ No If you smoked and quite, date you quit: _____

Do you drink alcohol? ☐ Yes ☐ No If you drank and quit, date you quit: _____

If you consume alcohol, approximately how many drinks per week? _____

Have you ever had a problem with alcohol and/or drugs? _____

Do you exercise regularly? ☐ Yes ☐ No

Current weight: _____ Current height: _____

Pharmacy where you fill your prescriptions, location and telephone #: _____

_____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM