**THOROUGHLY** complete this questionnaire. We know that it is a lot of writing, but it will help

the doctor to better diagnose and provide you the appropriate care.

FAX THIS COMPLETED QUESTIONNAIRE TO:

(321) 441-1559

**(If you cannot print/fax/scan/email this questionnaire back to us in advance,**

please arrange to arrive 15 minutes earlier than your appointment date/time to complete the form).

**Arrive for your appointment at \_\_am / pm on \_\_/­\_\_/ 2019**

Please bring questionnaire with you in case fax line is down

**OUR ADDRESS IS:** 801 N. Orange Avenue, Suite 535, Orlando, FL 32801

PHONE: (407) 644-0101

**PERSONAL INFORMATION**

### Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Circle one below | | |
| Single | Y | N |
| Married | Y | N |
| Divorced | Y | N |
| Widowed | Y | N |

Age\_\_\_\_\_\_ Right-handed Left-handed Sex: Male Female

Highest Education\_\_\_\_\_\_\_\_\_\_\_ Occupation /Profession: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# CURRENT MEDICAL COMPLAINTS

**Main Complaint:** Date symptom began and is it stable, on/off, getting worse/better.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

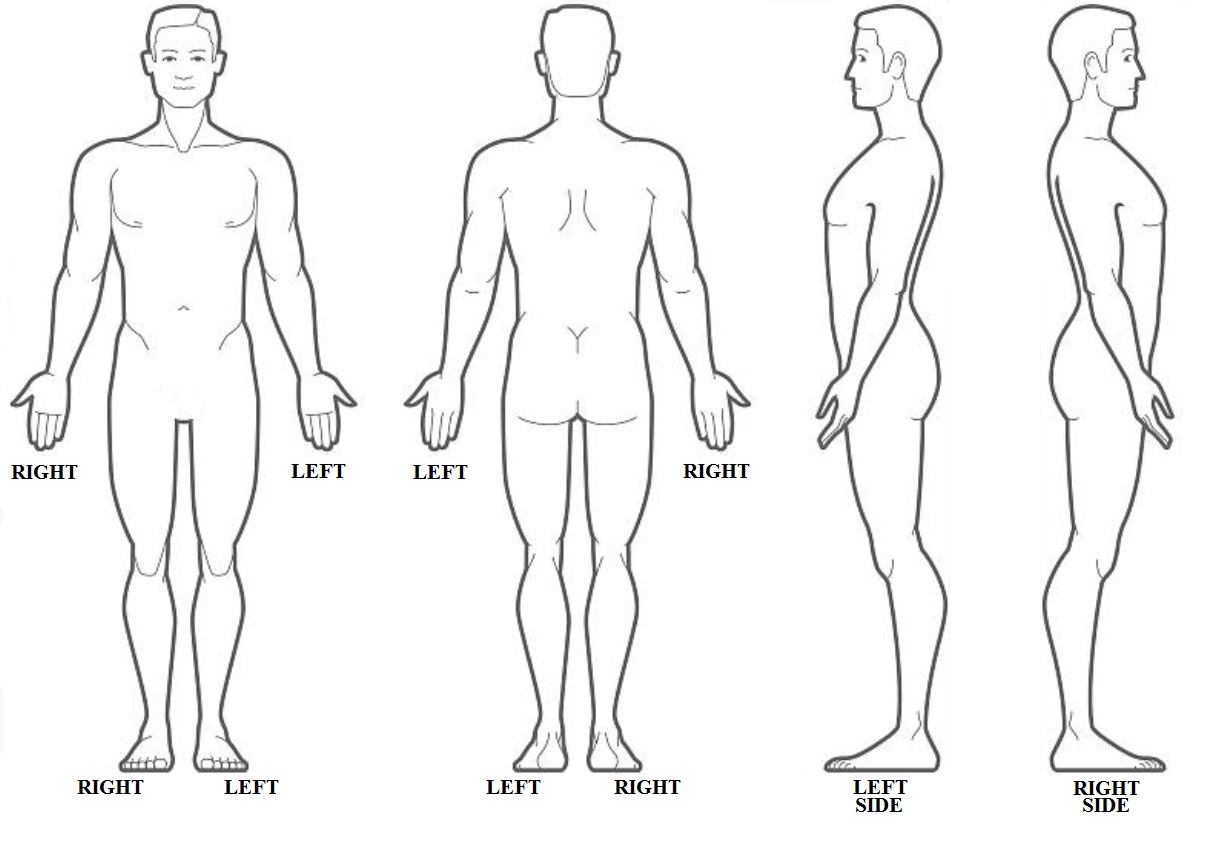
**Secondary Complaints:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Pain Assessment:** Mark the area(s) where you feel your symptoms.

///////= Stabbing pain; 0000= Tingling; XXXX= Burning; AAAA= Aching; TTTT= Throbbing; SSSS=Shooting; DDDD=Dull; NNNN= Numb.



**CLINICAL PATIENT INFORMATION SHEET**

*Print CLEARLY and leave no blank spaces*

Patient Do you smoke? \_\_\_yes \_\_\_no Packs/day =\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date you stopped smoking \_\_\_/\_\_\_/\_\_\_

Name of Primary Care/ Family Physician (if any): Do you drink? \_\_\_yes \_\_\_no Drinks/day =

Do you use drugs? \_\_\_yes \_\_\_no

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you use ILLICIT drugs? \_\_\_yes \_\_\_no

If yes, date stopped \_\_\_/\_\_\_/\_\_\_

Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List **ALL** medications you are taking at this time:

COMPLAINT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **NAME / STRENGTH & NUMBER**

­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If seen in an emergency room, name of hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been treated by another doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_Yes \_\_\_\_\_\_No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of other doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all surgeries you have had:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ List any medications you are allergic to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have **you** had **past history** of the following: \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Yes \_\_\_\_No Glaucoma Has any **member of your family** had a history of the

\_\_\_\_Yes \_\_\_\_No Diabetes following:

\_\_\_\_Yes \_\_\_\_No Thyroid Disease

\_\_\_\_Yes \_\_\_\_No High blood pressure \_\_\_\_Yes \_\_\_\_No Glaucoma

\_\_\_\_Yes \_\_\_\_No Lung Disease \_\_\_\_Yes \_\_\_\_No Diabetes

\_\_\_\_Yes \_\_\_\_No Heart disease \_\_\_\_Yes \_\_\_\_No Thyroid Disease

\_\_\_\_Yes \_\_\_\_No Stomach ulcer \_\_\_\_Yes \_\_\_\_No High blood pressure

\_\_\_\_Yes \_\_\_\_No Recent infections \_\_\_\_Yes \_\_\_\_No Lung disease

\_\_\_\_Yes \_\_\_\_No Cancer (type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Yes \_\_\_\_No Heart disease

\_\_\_\_Yes \_\_\_\_No HIV Positive (AIDS) \_\_\_\_Yes \_\_\_\_No Stomach ulcer

\_\_\_\_Yes \_\_\_\_No Hepatitis B \_\_\_\_Yes \_\_\_\_No Recent infections

\_\_\_\_Yes \_\_\_\_No Bleeding/blood clots \_\_\_\_Yes \_\_\_\_No Cancer (type) \_\_\_\_\_\_\_\_\_

\_\_\_\_Yes \_\_\_\_No Neck/back pain \_\_\_\_Yes \_\_\_\_No HIV Positive (AIDS)

\_\_\_\_Yes \_\_\_\_No Syphilis \_\_\_\_Yes \_\_\_\_No Hepatitis B

\_\_\_\_Yes \_\_\_\_No Arthritis \_\_\_\_Yes \_\_\_\_No Bleeding/blood clots

\_\_\_\_Yes \_\_\_\_No Neck/back pain

Any other medical problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Yes \_\_\_\_No Syphilis

\_\_\_\_Yes \_\_\_\_No Arthritis

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_

*How often do your symptoms affect you?*

Occasionally\_\_\_(0-33% of the day) Frequently\_\_\_(33-66%) Constant\_\_\_(66-100%)

*What time of the day your pain is most severe or frequent? (average)*

Wake up by the pain \_\_\_, when arrive to work\_\_\_, by noon\_\_\_, mid-afternoon\_\_\_, late in the evening\_\_, when lying down to sleep\_\_\_, Anytime\_\_\_, I haven’t noticed\_\_\_.

**Discomfort Rating**:

On a scale of 0 to 10 (**0** being **no discomfort**, # **5** if discomfort starts **interfering with activities**

and **10** being the **worst discomfort** you can imagine **and you would go to ER**):

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| What is your *Highest / Worst*  Level of discomfort? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| What is your *Lowest* Level of discomfort? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| What is your *Usual / Average* Level of discomfort? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| What is your *Current* Level of discomfort? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

###### Previous treatment for current complaints

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**S*leeping difficulties from pain (partly or mainly)*?** No/Yes

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### REVIEW OF SYSTEMS:

Please **CHECK** each that applies to you.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL:**

□yes □no Unexplained changes in weight

□yes □no Fever

□yes □no Chills

□yes □no Night sweats

**NEUROLOGICAL:**

□yes □no Unusual change in voice

□yes □no Seizures

□yes □no Loss of consciousness

□yes □no Memory difficulties

□yes □no Disorientation

□yes □no Difficulty with speaking

□yes □no Difficulty with writing

□yes □no Difficulty with reading

□yes □no Dysphagia

□yes □no Double vision

□yes □no Loss of vision

□yes □no Tremors

□yes □no Difficulty walking

□yes □no Weakness

□yes □no Numbness

□yes □no Changes in sensation

□yes □no Tingling

□yes □no Bleeding gums

**HEAD:**

□yes □no Headache

□yes □no History of head contusions

□yes □no Hearing

□yes □no Auditory problems

□yes □no Dizziness

□yes □no Ear buzzing

□yes □no Sinus (stuffy nose)

□yes □no Ear pain

□yes □no Dental problems

□yes □no Metal implants

**CARDIOLOGY/PULMONARY:**

□yes □no Chest pain

□yes □no Palpitations

□yes □no Murmur

□yes □no Swollen feet legs worse at the end of the

day.

□yes □no Cough

□yes □no Wheezing

□yes □no Shortness of breath walking up one-flight

**GASTROINTESTINAL:**

□yes □no Digestion problems

□yes □no Bloating

□yes □no Nausea

□yes □no Heartburns

□yes □no Vomiting

□yes □no Constipation

□yes □no Unexplained diarrheas

□yes □no Abdominal pain

□yes □no Sour mouth sensation after sleeping.

**GENITAL/URINARY:**

□yes □no Difficulty urinating

□yes □no Urge urinating

□yes □no Pain urinating

□yes □no Painful intercourse

□yes □no Vaginal secretions

□yes □no Bladder incontinence

□yes □no Kidney stones

□yes □no Kidney infections

**MUSCULAR/SKELETAL:**

□yes □no Diffuse muscle aching

□yes □no Fibromyalgia

□yes □no Legs or joint swelling

□yes □no Stiffness

□yes □no Painful foot sole or arch “*first steps in the*

*morning*”.

**SKIN/HAIR:**

□yes □no Changes in skin moles

□yes □no Non-healing ulcers

□yes □no Dry skin

□yes □no Itching

□yes □no Nail fungus

**ENDOCRINE/HEMATOLOGICAL/**

**IMMUNE:**

□yes □no HIV positive

□yes □no Hepatitis

□yes □no Fainting

□yes □no Swollen armpit

□yes □no Swollen groin glands,

□yes □no Pale color

□yes □no Bleeding disorders

□yes □no Recurrent infections

Stairs.

Is there significant stress at work? Yes\_\_ No\_\_\_, at home? Y\_\_\_ No\_\_\_ Do you feel this stress makes your pain worse Yes\_\_\_ No\_\_\_\_

### Any Food intolerance or allergy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Upon agreement between the Patient (and/or Responsible Person) and the treating Physician, I hereby authorize the Physicians of M.D. Diagnostic Specialists, LLC and /or Rolando Amadeo, MD; to administer such Medical Care as may be deemed advisable in diagnosis and treatment of the Patient.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Or legal guardian, if minor or patient incapacity)