San Antonio Family Psychiatry
Psychiatry for Adults, Children and Adolescents
San Antonio
16007 Via Shavano, Ste. 102
San Antonio, TX 78249
Safamilypsychiatry.com

MEDICAL QUESTIONNAIRE

Name of Patient: _____ DOB: _____
Date Completed: _____
If completed by other than patient, Name of Person Completing Form: _____

How is your (or your child's, if he/she is the patient)
health?_____

Do you (or your child, if he/she is the patient) presently have any of the following issues:

Changes in sleep: __Yes __No
If yes, explain:
_____

Fatigue/low energy: __Yes __No
If yes, explain:
_____

Fever/chills: __Yes __No
If yes, explain:
_____

Nausea/vomiting: __Yes __No
If yes, explain:
_____

Dizziness/lightheadedness/fainting: __Yes __No
If yes, explain:
_____

Visual problems: __Yes __No
If yes, explain:
_____

Hearing problems: __Yes __No
If yes, explain:
_____

Respiratory allergies: __Yes __No
If yes, explain:
_____

Seizure disorder or head injury: __Yes __No
If yes, explain:
_____

Memory problems: __Yes __No
If yes, explain:
_____

Heart Problems, stroke, high blood pressure, high cholesterol: __Yes __No
If yes, explain:
_____

Heart structural abnormalities, abnormal heart rhythms, fainting, or family history of these issues or of sudden death at a young age:
__Yes __No
If yes, explain:
_____

Breathing problems or other respiratory issues: __Yes __No
If yes, explain:
_____

Stomach/Gastrointestinal problems, such as diarrhea, constipation or other gastrointestinal problems:
__Yes __No
If yes, explain:
_____

For Females, do you have periods on a regular basis: __Yes __No
If yes, list first day (date) of last period
_____

Any bladder/urinary problems: __Yes __No
If yes, explain:
_____

Do you have a primary care physician? __Yes __No
If yes, please list name of physician and contact information:
_____
If additional health issues, please list:
_____
_____
Medication Allergies (please list): _____

Medications (please list):
_____
_____