

PERSONAL QUESTIONNAIRE

DR. WALTER T SOROKOLIT

TODAY'S DATE: _____

PLEASE FILL IN THE ENTIRE BLANK SPACES BELOW. THIS INFORMATION IS INTENDED FOR THE DOCTOR'S USE ONLY. PLEASE PRINT!!!

PATIENT'S NAME: _____ HOME PHONE: _____
LAST, FIRST, MIDDLE

EMAIL: _____

CELL PHONE: _____ FAX # _____

ADDRESS: _____
STREET CITY, STATE, ZIP CODE

LANGUAGES YOU SPEAK: _____ AGE: _____ DATE OF BIRTH: _____
MONTH, DAY, YEAR

HEIGHT: _____ WEIGHT: _____ PATIENT'S SOCIAL SECURITY #: _____
ARE YOU _____ RIGHT or _____ LEFT Handed SEX: Male / Female (PLEASE CIRCLE ONE)

NAME OF EMPLOYER: _____ PHONE #: _____

ADDRESS: _____ OCCUPATION: _____

MARITAL STATUS: **S M D W O** NAME OF SPOUSE OR PARENT: _____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____

PHONE # RELATIONSHIP TO PATIENT: _____

WHO REFERRED YOU / HOW DID YOU HEAR ABOUT US _____

NAME OF FAMILY DOCTOR: _____ PHONE: _____

NAME OF PRIMARY INSURANCE: _____ PHONE _____

ADDRESS FOR CLAIMS: _____

POLICY # of INSURED: _____ GROUP #: _____

NAME OF INSURED (IF OTHER THAN PATIENT): _____

SOCIAL SECURITY # of INSURED: _____ BIRTH DATE: _____

NAME OF EMPLOYER & PHONE # (IF DIFFERENT THAN ABOVE): _____

NAME OF SECONDARY INSURANCE: _____ PHONE: _____

ADDRESS FOR CLAIMS: _____

POLICY # of INSURED: _____ GROUP: _____

NAME OF INSURED (IF OTHER THAN PATIENT): _____

SOCIAL SECURITY # OF INSURED: _____ BIRTH DATE: _____

NAME OF EMPLOYER & PHONE # (IF DIFFERENT THAN ABOVE): _____

DR. WALTER T. SOROKOLIT

WHY ARE YOU SEEING THE DOCTOR TODAY _____
HOW LONG HAVE YOU HAD THESE SYMPTOMS _____
LIST ANY CURRENT MEDICATION YOU ARE TAKING _____

HAVE YOU TAKEN ANY ASPIRIN IN THE LAST 2 WEEKS? YES () NO ()
HAVE YOU EVER HAD ANY PHSYCIATRIC TREATMENT? YES () NO ()
DO YOU HAVE A SUBSTANCE OR ALCOHOL DEPENDENCY? YES () NO ()
DO YOU SMOKE or USE SMOKELESS TOBACCO PRODUCTS _____ IF SO, HOW MUCH _____
ARE YOU TAKING DIET PILLS _____ DO YOU TAKE VITAMINS _____
DATE OF LAST IMMUNIZATION _____

ALLERGIES (PLEASE CIRCLE YES or NO , AND LIST THE EFFECTS FROM THE MEDICATION)

PENICILLIN Y N _____ TAPE Y N _____
IODINE Y N _____
OTHER _____

LIST ALL HOSPITALIZATIONS, OPERATIONS (INCLUDING PLASTIC SURGERY) & SERIOUS INJURIES

YEAR	HOSPITALIZATION-OPERATION-INJURY	HOSPITAL & LOCATION
_____	_____	_____
_____	_____	_____
_____	_____	_____

ILLNESS & MEDICAL PROBLEMS (PLEASE CIRCLE YES or NO TO ALL THAT APPLY)

DIZZY SPELLS	Y N	HIGH BLOOD PRESSURE	Y N		
GLAUCOMA	Y N	LOW BLOOD PRESSURE	Y N		
BLEEDING DISORDER	Y N	BLEED EASILY	Y N		
ANEMIA	Y N	GALL BLADDER TROUBLE	Y N		
SINUS TROUBLE	Y N	NOSE OBSTRUCTION	Y N		
SWELLING IN NECK	Y N	HEART MURMUR	Y N		
ANKLE SWELLING	Y N	HEART ATTACK	Y N		
ASTHMA	Y N	OTHER HEART CONDITION	Y N		
BRONCHITIS	Y N	STROKE	Y N		
STOMACH ULCER	Y N	DIABETES	Y N		
SCARLET FEVER	Y N	ARTHRITIS	Y N		
PNEUMONIA	Y N	MONONUCLEOSIS	Y N	HEPATITIS	Y N
TUBERCULOSIS	Y N	CONVULSION / SIEZURES	Y N	HIV / AIDS	Y N
OTHER LUNG PROBLEM	Y N	TROUBLE W/ ANESTHESIA	Y N	PARALYSIS	Y N

CANCER Y N YEAR & TYPE OF CANCER _____

WOMEN ONLY

DISCHARGE FROM NIPPLES Y N FIBROCYSTIC DISEASE Y N
LUMPS OR RECENT CHANGES IN SIZE OF BREASTS Y N
PREVIOUS MAMMOGRAM Y N YEAR OF LAST MAMMOGRAM _____

FAMILY HISTORY

TUBERCULOSIS Y N DIABETES Y N
RHEUMATOID ARTHRITIS Y N HEART DISEASE Y N
HIGH BLOOD PRESSURE Y N BLEEDING TENDENCY Y N
BLOOD DISORDERS (SICKLE CELL ANEMIA, ETC.) Y N
CANCER Y N
RELATIONSHIP & TYPE OF CANCER _____