ANTHONY G. GIATRAS, M.D.

Patient Questionnair e

Date ______________

Social Security # ______________

Patient ______________________________
(First) (Middle) (Last)

Date of Birth ______________ Age ______________

Handedness (right or left) ______________________________

Occupation ______________________________

Review of symptoms: Do you have any of the following symptoms? If "YES" please describe briefly.

Recent fevers? YES NO ______________________________

Recent weight change? YES NO ______________________________

Vision problems? YES NO ______________________________

Hearing problems? YES NO ______________________________

A heart condition? YES NO ______________________________

Breathing or respiratory problems? YES NO ______________________________

Stomach or gastrointestinal problems? YES NO ______________________________

Pain or Weakness in your muscles? YES NO ______________________________

A skin disorder? YES NO ______________________________

A psychiatric condition? YES NO ______________________________

Endocrine (hormone) problems? YES NO ______________________________

A blood disorder? YES NO ______________________________

Allergies or immune problems? YES NO ______________________________

Do you smoke? YES NO If "YES" how much? ______________________________

Do you drink? YES NO If "YES" how much? ______________________________