Mark Thornton, M.D.
Personal Physician

MARK L. THORNTON, MD, FACP / EXECUDOC, INC.

PATIENT INFORMATION

In order to provide the best medical care possible, I must know not only what your present symptoms are, but also what diseases you have been exposed to and what problems you may be at risk for developing. For this reason you are requested to carefully fill out this screening health questionnaire. This along with the history and examination I will obtain when you visit with me will provide a complete medical evaluation of your current and potential medical problems.

DATE:

Patient's Name (Last, First):	Sex: ❑ F ❑ M	DOB:	Age:
Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced	SSN:		
Mailing Address: (Street, City, State, Zip):			
Home Address: (Steet, City, State, Zip):			
Home Phone ( )	Work Phone ( )	Cell Phone ( )	
Home Fax ( )	Work Fax ( )	Email Address:	
What is your primary means of contact? ❑ Home Phone ❑ Work Phone ❑ Cell Phone ❑ Email ❑ Fax (Home or Work)			
Insurance Company:	Policy No:	Group No:	
Primary Insured: ❑ Self ❑ Spouse ❑ Parent	Primary Insured Name	SSN	DOB

PLEASE COMPLETE THE FOLLOWING QUESTIONS:

Please state why you are coming to see the doctor:

What are your expectations of this visit?

INJURIES ~ Please list serious injuries and broken bones with approximate dates:

OPERATIONS ~ Please list the operations you have had, do not omit minor operations such as tonsils, vasectomy, D&C, etc.:

Operation:	Date:	Hospital:	Surgeon:

HOSPITALIZATIONS ~ Please list your hospitalizations other than those described above:

Illness:	Date:	Hospital:	Physician:

MEDICATIONS ~ Please list all current medications including vitamins and supplements:

Medication:	Strength:	Dosage:	Medication:	Strength:	Dosage:

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE BEEN TROUBLED WITH:

GENERAL:	❑ Weight loss (how much _____)	❑ Weight gain (how much _____)	❑ Over what period of time? _____
	❑ Poor appetite	❑ Weakness	❑ Night sweats
SKIN:	Dermatologist:	Phone no:	Date of last exam:
	❑ Burning	❑ Rash	❑ Hives ❑ Acne ❑ Psoriasis ❑ Melanoma ❑ Change in mole
HEAD:	❑ Headache (more than one per week)	❑ Dizziness/lightheadedness	❑ History of migraines
EYES:	❑ Double vision	❑ Blurred vision	❑ Redness ❑ Tearing
	Ophthalmologist:	Phone no:	Date of last exam:
EARS:	❑ Earache	❑ Drainage or discharge from ear	❑ Vertigo ❑ Tingling or other noises
	❑ Difficulty hearing (how long? _____)		
NOSE:	Do you frequently have a stuffy nose when you do not have a cold?	❑ Yes	❑ No
	❑ Frequent nose bleeds	❑ Post nasal drip	❑ Trouble smelling ❑ Allergies (If yes, to what?)
MOUTH:	❑ Dentures	❑ Dry mouth	❑ Sore or burning tongue ❑ Problems with teeth
	❑ Changes in taste	❑ Hoarseness	❑ Frequent sore throats ❑ Gingivitis
NECK:	❑ Frequent stiffness	❑ Goiter	❑ Pain ❑ Frequent swollen glands
BREASTS:	❑ Tenderness	❑ Nipple discharge	❑ Lumps or masses ❑ Breast biopsy
	❑ Family history of breast cancer. Who?		

RESPIRATORY:	❑ Cough	❑ Coughing up blood or blood streaked phlegm	❑ Pneumonia	❑ Bronchitis
	❑ Wheezing/asthma	❑ Sputum (phlegm) production in the morning	❑ Emphysema	
	❑ Coughing after eating			
CARDIOVASCULAR:	❑ Palpitations	❑ Thumping in the chest	❑ Irregular heart beat	❑ Fainting spells
	❑ Swelling of ankles	❑ Cramps in your legs on walking	❑ Cramps in leg at night	❑ Nocturnal cough
	❑ Shortness of breath	❑ Chest pain or discomfort/angina	❑ High blood pressure	
	❑ Congestive heart failure		❑ Heart murmur/abnormal heart valve	
	❑ Can you climb two flights of stairs without stopping? ❑ Yes ❑ No			
GASTROINTESTINAL:	❑ Pain	❑ Heartburn	❑ Intolerance to any foods	❑ Vomiting
	❑ Diarrhea	❑ Constipation	❑ Recent change in bowel habits	❑ Jaundice
	❑ Clay colored stools	❑ Black or tarry stools	❑ Blood in the stool or on toilet paper	❑ Rectal itching
	❑ Gall bladder trouble	❑ Ulcers	❑ Vomiting of blood or coffee ground-like material	
	❑ Liver disease	❑ Cirrhosis	❑ Hiatal hernia	❑ Pancreatitis
	❑ Diverticulitis	❑ Hemorrhoids	❑ Esophagitis/reflux	❑ Colon polyps
	❑ Family history of colon cancer: ❑ Yes ❑ No			
	Colonoscopy:	Date:	Gastroentorologist:	
GENITOURINARY:	❑ Kidney Stones	❑ Blood in urine	❑ Coca cola colored urine	❑ Urgency
	❑ Burning	❑ Straining on urination		
	How many times do you get up at night to urinate?		How long have you been doing this?	
	MEN:	❑ Discharge from penis	❑ Prostatitis	❑ Pain or swelling
		❑ Erectile dysfunction	❑ Last PSA or rectal exam:	
	WOMEN:	❑ Discharge from vagina	❑ Itching	❑ Cramps
		❑ Bleeding between periods		
		Date of last pelvic exam?	Date of last PAPS smear?	
		Date of last menstrual period?	Do you use birth control pills? ❑ Yes ❑ No	
		Onset age of mentrual period?	Days between periods?	
		Duration of flow?	Date of last bone density exam?	
PREGNANCIES?	How many pregnancies?	Live births?	Weight of largest baby?	
	During pregnancy, did you have any of the following?			
	❑ Diabetes	❑ Seizures	❑ High blood pressure	❑ Swelling of ankes ❑ Albumin or protein in urine
MUSCULOSKELETAL:	❑ Arthritis	❑ Joint stiffness in the morning	❑ Bone pain	❑ Muscle pain
	❑ Swollen joints	❑ Low back pain	❑ Varicose veins	❑ Phlebitis
	❑ Cold or blue fingers	❑ Rheumatoid arthritis		

NEUROLOGICAL:	❑ Seizures	❑ Epilepsy	❑ Stroke	❑ Paralysis	❑ Muscle weakness
	❑ Tremors	❑ Muscle wasting	❑ Numbness	❑ Neuritis	❑ Fainting
GLANDS:	❑ Goiter	❑ Thyroid disease	❑ Diabetes	❑ Change in texture of hair	
BLOOD:	❑ Anemia	❑ Easy Bruisability	❑ Bleeding disorders		
PSYCHIATRIC:	❑ Insomnia	❑ Hopeless feeling	❑ Feeling Blue	❑ Crying	
	❑ Shyness	❑ Difficulty relaxing	❑ Excess worrying	❑ Sexual problems	
	❑ Fatigue	❑ Thoughts of suicide	❑ Loss of interest in pleasurable activities		
	Have you ever been hospitalized for emotional reasons? ❑ Yes ❑ No				
	Have you ever been on medication for emotional reasons? ❑ Yes ❑ No				
	Reason/diagnosis:				
	Have you ever been to see a psychiatrist or psychologist? ❑ Yes ❑ No			Name:	

ALLERGIES ~ Please provide a complete list of all allergies:

Allergen (including medications)	Type of reaction:	Date of last reaction:

HABITS ~ Please indicate your average daily consumption of the following and how long you have used them:

Alcohol		Coffee	
Beer		Tea	
Wine		Cigarettes/ smokeless tobacco	
Marijuana		Pipes & cigars	

EMPLOYMENT

What type of work do you do?

What type of work does your spouse do?

IMMUNIZATIONS ~ Please indicate the last year you received each of the following immunizations:

Tetanus

Infuenza (flu)

Hepatitis B

TB Skin Test ❑ Positive ❑ Negative

Pneumonia

Measles/Mumps/Rubella (MMR)

FAMILY HISTORY ~ Please include hypertension, heart disease, cancer, diabetes, thrombosis, etc.

Family Member	Age if Alive	Age at Death	Medical Problems or Cause of Death
Spouse			
Mother			
Father			
Brothers			
Sisters			
Children			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

COMMENTS: