THE MEMORIAL HOSPITAL
North Conway, NH 03860

Date: ____________ Time: ____________

PATIENT QUESTIONNAIRE

Age: ________ Date of Birth: ____________

Patient Name: ______________________________ Height: ________ Weight: __________

or Name of Person Completing the Form: ______________________________

Home Phone Number: ______________________________

Name of Private Physician: ____________________ Phone Number: ____________________

Reason You Are Being Seen Today: ______________________________

Reviewed by: ______________________________, RN/LPN

Medical / Surgical History:

Recent cold/sore throat ❒ Yes ❒ No

Could you be pregnant? ❒ Yes ❒ No

Last menstrual period ____________________

Daily Care:

Do you have any of the following? Please check all that apply:

- ❒ Dietary Restrictions/Preferences: ____________________
- ❒ Dentures, Bridges, Caps - List: ____________________
- ❒ Loose Teeth
- ❒ Eye Glasses
- ❒ Contact Lenses
- ❒ Hearing Aid
- ❒ Prosthesis – List: ____________________
- ❒ Ostomy

Allergies ❒ Yes ❒ No

Medications/Anesthesia Allergies
List: ______________________________

Food Allergies ❒ Yes ❒ No
List: ______________________________

Environmental Allergies ❒ Yes ❒ No
List: ______________________________

Other: Reaction to balloons, bananas, rubber gloves, kiwi ❒ Yes ❒ No

Social/Cultural:

Do you live ❒ Alone
❒ With Spouse and/or Family
❒ Other: ____________________

Do you have spiritual/religious practices that need to be considered? ❒ Yes ❒ No

Do you feel unsafe at home? ❒ Yes ❒ No

Do you use alcohol? ❒ Yes ❒ No
If yes, amount ____________ per day/week

Do you use street/recreational drugs? ❒ Yes ❒ No
If yes, Type: __________ Amount: ______ per day/week

Do you use tobacco products? ❒ Yes ❒ No
If yes, Type: __________ Amount: __________ per day

Do you have persistent or chronic pain? ❒ Yes ❒ No
If yes, where? ______________________________

What relieves it? ______________________________

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V
OVER please

Health Conditions:

Do you have a communicable disease (i.e., ❒ Hepatitis, ❒ Positive PPD, ❒ Tuberculosis, ❒ HIV, ❒ Other).
If Other, please specify: ______

Have you ever had (or still have) any of the following? Please check all that apply.

❒ Stroke / Black Outs	❒ Seizures
❒ Mood Swings / Depression	❒ Respiratory Problems / Breathing Problems
❒ Heart Disease	❒ High Blood Pressure
❒ Gastrointestinal (stomach, bowel) Problems	❒ Weight Gain/Loss
❒ Kidney / Urinary Difficulties	❒ Joint Discomfort / Walking Problems
❒ Cancer	❒ Diabetes
❒ Liver Problems	❒ Thyroid Disease

Person to notify when ready for discharge:

Name: ______ Relation: ______

Telephone: ______ (Home) Telephone: ______ (Work)

Immunizations:

Date of Last **Tetanus** Shot: ______	Date of Last **Flu** Shot: ______	Date of Last **Pneumovax** Shot: ______

Medications/Supplements:

Please list all the medicine that you take regularly including over the counter medications and/or herbal preparations

Name:	Dose:	Frequency:	Last Dose: