Christopher Kowalski., M.D.
Franciscan Med Bldg Suite 106
1205 Langhorne-Newtown Rd
Langhorne, PA 19047

QUESTIONNAIRE

Patient Label

PATIENT NAME: ______________________ AGE: ________

DATE OF BIRTH: ______________ SEX: M F HT: ________ WT: ________

DAY PHONE: ( ) ____________ CELL PHONE: ( ) ____________ EVENING PHONE: ( ) ____________

FAMILY DOCTOR: ______________________ DATE LAST SEEN: ________

CITY: ______________________ PHONE: ( ) ____________

Do you have any medication allergies? ☐ Yes ☐ No If yes please list the allergies and reactions you have below:

____________ ____________ ____________ ____________

____________ ____________ ____________ ____________

____________ ____________ ____________ ____________

Check if an allergy or reaction to: ☐ Latex ☐ Contrast dye ☐ Adhesive tape ☐ Iodine ☐ Dairy ☐ Other ____________

A. To your knowledge, do you now have or have you ever had any of the following:

Respiratory Problems (breathing problems)	Yes	No	Cardiovascular Problems (heart or circulatory problems)	Yes	No	Neurologic Problems	Yes	No
Recent cold, Bronchitis or Pneumonia			Irregular Heart Beat			Tremors/Parkinson's		
Asbestosis			Mitral Valve Prolapse			Stroke/TIA/Mini-Stroke		
History of Asthma or Wheezing			Heart Murmur			Multiple Sclerosis or Polio		
Sleep Apnea/Excessive Snoring			Rheumatic Fever			Weakness or Paralysis		
Use CPAP			High blood Pressure			Head Injury		
Shortness of Breath with Exertion or at Rest			Fast Heartbeat/Palpitations			Neuropathy		
Emphysema			Heart Attack			Epilepsy/Seizures		
Chronic Bronchitis			High Cholesterol			Migraines		
Chronic cough or Lung Problems			Heart Failure			Vertigo		
Tuberculosis/year:			Chest Discomfort or Tightness			Restless Leg Syndrome		
Hematologic Problems (Bleeding Problems)	**Yes**	**No**	Problems with Arteries in neck			**Endocrine Problems**	**Yes**	**No**
			Problems with Poor circulation to legs & feet			Thyroid Disorder		
History of Anemia (low blood count)			**Gastrointestinal Problems (Digestive Problems)**	**Yes**	**No**	Parathyroid Disorder		
Sickle-Cell Anemia/Trait						Diabetes		
History of Bleeding or Bruising			Liver Disease/Jaundice/Hepatitis			Adrenal Disorder		
Blood Transfusion			Chronic Heartburn			**Urology Problems**	**Yes**	**No**
Phlebitis/Blood clots			GI Bleed/Ulcer			Kidney Stones		
VonWillobrand's disease			Hiatal Hernia			Enlarged Prostate		
Psychological Problems (Mental-Health Problems)	**Yes**	**No**	Reflux			Dialysis		
			Crohns			Bladder Retention		
Anxiety/Depression			Diverticulitis			Stress Incontinence		
Panic Disorders			IBS/Ulcerative Colitis			Urinary Tract Infections		
Anorexia/Bulimia			Gastroparesis			Interstitial Cystitis		
Post Traumatic Stress			Pancreatitis			Frequency		
Alzheimer's/Dementia						**Developmental Problems**		
Schizophrenia						Mental Retardation		
Bipolar						Learning Disabilities		
Other Problems	**Yes**	**No**	**Other Problems**	**Yes**	**No**	Autism		
Cancer			Any loose or Chipped Teeth			ADHD		
HIV/AIDs			Caps/Crowns			**Other Problems**	**Yes**	**No**
History of Shingles			Braces			Hearing/Impaired		
Chronic Neck Problems			Dentures			Use of Hearing Aids		
Chronic Back Problems			Implants			Deafness		
Temporal Mandibular Joint Disease			Veneers			Osteoporosis/Osteopenia		
Scoliosis (curvature of the spine)			Contacts/Glasses			Arthritis: OA/RA		
Glaucoma			Blindness/Visual Impairment			Gout		