Caroline D. Zohoury, D.O.
115 N. Rochester Road
Clawson, MI 48017
P: 248-588-0400
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Primary Care Clinic
Patient Questionnaire

Last Name:	**First Name:**	**DOB:**	☐**F** ☐**M**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		**Occupation:**	
Previous or referring doctor:		**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

Immunizations (Include approximate year or age)			
	☐ Tetanus	☐ Pneumonia/Pneumovax	☐ Hepatitis A
	☐ Influenza (Flu)	☐ Prevnar 13	☐ Hepatitis B
	☐ Gardasil (HPV)	☐ Shingles vaccine/Zostavax	

Past or Present Medical History: (check all that apply to you)			
☐ Alcohol/ Drug problem	☐ Emphysema/COPD	☐ Liver Disease	☐ Blood Clots
☐ Anemia	☐ Heart – Attack	☐ Osteoporosis	☐ Peripheral Artery Disease
☐ Anxiety	☐ Heart–Coronary Artery Dis.	☐ Prostate problem	☐ Neuropathy
☐ Arthritis	☐ Heart- Heart Failure/ CHF	☐ Psychiatric- Depression	☐ Sleep Apnea
☐ Asthma	☐ High Blood Pressure	☐ Psychiatric Disorder--other	☐ Heart Murmur
☐ Atrial Fibrillation	☐ High Cholesterol	☐ Seizure Disorder	☐ Migraines
☐ Dementia	☐ Hypothyroidism (low)	☐ Stroke	☐ Hepatitis
☐ Diabetes	☐ Hyperthyroidism (high)	☐ Ulcers of the Stomach	☐ Diverticulosis
☐ Cancer—	☐ Kidney Disease	☐ STD/ sexual infection	☐ Colon Polyps
Type:		☐ Abnormal Pap Test	☐ Positive TB test

Surgeries (Include Year or Age at time of surgery)		
☐ Appendectomy	☐ Tonsillectomy	☐ C-Section (Cesarean)
☐ Cardiac Bypass (CABG)	☐ Hernia Repair	☐ Hysterectomy- Partial
☐ Cardiac Angioplasty/Stent	☐ Prostate Surgery	☐ Hysterectomy- Total
☐ Gallbladder Laparoscopic	☐ Vasectomy	☐ Tubal Ligation
☐ Gallbladder Open	☐ Cataract Surgery: ☐ Left ☐ Right	☐ Breast Surgery: ☐ Left ☐ Right
☐ Orthopedic (type):		
☐ Other Surgery:		

Screening Tests	Approx Date:			Approx Date:		
Cholesterol Test		☐ Normal	☐ Abnormal	Pap Smear		☐ Normal ☐ Abnormal
Colonoscopy		☐ Normal	☐ Abnormal	Mammogram		☐ Normal ☐ Abnormal
Prostate Test		☐ Normal	☐ Abnormal	Bone Density Test		☐ Normal ☐ Abnormal
Dental Exam		☐ Normal	☐ Abnormal			
Eye Exam		☐ Normal	☐ Abnormal	☐ Glasses	☐ Contacts	☐ Cataracts

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MEDICATIONS: List prescribed and over-the-counter medications.		
DRUG NAME:	DOSE & DIRECTIONS:	REASON:

ALLERGIES/ REACTIONS to Medications:	
DRUG NAME:	REACTION/ COMMENTS:
LIST ANY FOOD OR ENVIRONMENTAL ALLERGIES AND REACTIONS:	

SEXUAL HEALTH			
☐ Sexually active	☐ Not currently sexually active	☐ Never sexually active	# partners in past year:
History of Sexually Transmitted Infection ? ☐ No ☐ Yes Type/date:			
Current contraception method:		Previous methods:	
# children:	**For Women:** (# pregnancies:) (# miscarriages:) (# abortions:)		

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary (No exercise)
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	☐ Occasional vigorous exercise (i.e., work or recreation, 1 - 3x/week for 30 min.)
	☐ Regular vigorous exercise (i.e., work or recreation >3x/week for 30 minutes)

Tobacco	**Cigarette use:**	☐ Never	☐ Former smoker. Quit date or age:	
		☐ Current smoker----	# packs/day:	# years:
	Other tobacco use:	☐ Pipe	☐ Cigars	☐ Chewing tobacco

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Alcohol	Do you drink alcohol? ☐ No ☐ Yes : ☐ 0-1 time/month ☐ 2-4 times/month ☐ every week	
	Each week, how many: Servings of beer? Glasses of wine? Shots/mixed drinks?	
	When did you last have more than 4 drinks in one day? _____	
	Do you feel you should cut down on drinking?	☐ Yes ☐ No
	Do people annoy you by nagging about your drinking?	☐ Yes ☐ No
	Have you ever felt guilty about drinking?	☐ Yes ☐ No
	Have you ever had a morning drink to steady your nerves?	☐ Yes ☐ No

Drugs	Have you used recreational or street drugs within the last 2 years?	☐ Yes ☐ No
	Have you ever used recreational drugs with a needle?	☐ Yes ☐ No

FAMILY HEALTH HISTORY

Family Member			Age	MEDICAL CONDITIONS (Indicate Healthy or: diabetes, high blood pressure, cholesterol, heart disease, stroke, cancer &type)
Mother		☐ Living ☐ Deceased		
Father		☐ Living ☐ Deceased		
Grandmother *Mother's Side*		☐ Living ☐ Deceased		
Grandfather *Mother's Side*		☐ Living ☐ Deceased		
Grandmother *Father's Side*		☐ Living ☐ Deceased		
Grandfather *Father's Side*		☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
Sibling	☐ M ☐ F	☐ Living ☐ Deceased		
		☐ Living ☐ Deceased		
		☐ Living ☐ Deceased		

Reviewed by/ Date:

Caroline D. Zohoury, D.O.

New Patient or Annual Preventive Visit

Name: **Today's Date:**

Date of Birth:

Check the box if you are currently experiencing any of the following:

GENERAL:
- ☐ Fatigue
- ☐ Fever
- ☐ Weight gain > 10 lbs
- ☐ Weight loss > 10 lbs

SKIN:
- ☐ Rash
- ☐ New/changing skin lesion
- ☐ Nail changes
- ☐ Hair loss

EYES/EARS/NOSE/THROAT:
- ☐ Vision changes
- ☐ Decreased hearing
- ☐ Ear pain
- ☐ Ringing in ears
- ☐ Nasal congestion
- ☐ Nose bleeds
- ☐ Hoarse voice
- ☐ Sore throat
- ☐ Sneezing
- ☐ Sinus problems
- ☐ Lump in neck

RESPIRATORY:
- ☐ Wheezing
- ☐ Difficulty breathing
- ☐ Night sweats
- ☐ Bloody sputum
- ☐ Productive cough
- ☐ Dry cough
- ☐ Shortness of breath

CARDIOVASCULAR:
- ☐ Chest pain
- ☐ Racing heart
- ☐ Irregular heartbeat
- ☐ Shortness of breath
- ☐ Leg pain with walking
- ☐ Ankle or Leg swelling
- ☐ Decreased exercise tolerance
- ☐ Awakening at night due to trouble breathing

GASTROINTESTINAL:
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Trouble swallowing
- ☐ Heartburn
- ☐ Acid reflux
- ☐ Rectal bleeding

MUSCULOSKELETAL:
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Muscle pain
- ☐ Muscle weakness

HEMATOLOGIC:
- ☐ Easy bruising
- ☐ Prolonged bleeding
- ☐ Enlarged lymph nodes

NEUROLOGIC:
- ☐ Headaches
- ☐ Dizziness/vertigo
- ☐ Numbness/tingling
- ☐ Passing out
- ☐ Difficulty walking
- ☐ Seizures
- ☐ Tremor
- ☐ Frequent falls

PSYCHIATRIC:
- ☐ Depression
- ☐ Anxiety
- ☐ Hallucinations
- ☐ Mood swings
- ☐ Suicidal thoughts
- ☐ Insomnia/sleep problems
- ☐ Psychiatric treatment

ENDOCRINE:
- ☐ Change in appetite
- ☐ Cold or heat intolerance
- ☐ Increased thirst
- ☐ Changes in sex drive
- ☐ Hair loss or excess growth

ALLERGIC/IMMUNOLOGIC:
- ☐ Allergy/Hayfever symptoms
- ☐ Itching
- ☐ Frequent infections
- ☐ Exposure to infection

BREAST:
- ☐ Breast lump/mass
- ☐ Breast pain
- ☐ Nipple discharge
- ☐ Rash on breast

GENITOURINARY:
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Loss of bladder control
- ☐ Difficulty passing urine
- ☐ Hernia

MEN:
- ☐ Difficulty starting stream
- ☐ Change in urine stream
- ☐ Penile discharge
- ☐ Testicular pain or mass
- ☐ Erection difficulties

WOMEN:
- ☐ Pelvic pain
- ☐ Irregular periods
- ☐ Vaginal discharge
- ☐ Excessive vaginal bleeding
- ☐ Bleeding after menopause
- ☐ Vaginal dryness
- ☐ Hot flashes
- ☐ Pain with intercourse

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I CONSENT TO TREATMENT FOR MEDICAL CARE.

I AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS TO MY PHYSICIANS AND INSURANCE COMPANY. I ALSO AUTHORIZE FAX TRANSMITTAL OF MY MEDICAL RECORDS.

IF YOUR INSURANCE COMPANY REQUIRES A REFERRAL FORM AND YOU DO NOT OBTAIN ONE, YOU WILL BE RESPONSIBLE FOR THE BILL. ALL REFERRAL FORMS ARE THE RESPONSIBILITY OF THE PATIENT TO OBTAIN.

I UNDERSTAND THAT PAYMENT OF CHARGERS INCURRED IS DUE AT THE TIME OF SERVICE UNLESS OTHER DEFINITE FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO TREATMENT.

I HEREBY AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO DR. ZOHOURY THE AMOUNT(S) DUE ON MY CLAIM FOR SERVICES RENDERED TO ME OR MY DEPENDENT. I FURTHER AGREE THAT SHOULD THE AMOUNT BE INSUFFICIENT TO COVER THE ENTIRE MEDICAL SURGICAL EXPENSE, I WILL BE RESPONSIBLE TO THE DOCTOR FOR PAYMENT OF THE ENTIRE BILL, AND IF THE BILL REMAINS UNPAID FOR THIRTY DAYS, I WILL BE RESPONSIBLE FOR THE BILLING FEE'S.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT FOR TREATMENT, FINANCIAL RESPONSIBILITY, RELEASE OF MEDICAL INFORMATION, AND INSURANCE AUTHORIZATION.

I UNDERSTAND THAT DUE TO RISING COST THAT THERE WILL BE A $8.00 MONTHLY CHARGE FOR ALL BALANCES 30 DAYS PAST DUE.

_____
NAME (PLEASE PRINT)

_____
SIGNATURE

_____
DATE

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In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communicator or PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone ( ) _____

- ☐ Ok, to leave a detailed message
- ☐ Leave a message with call back number only

☐ Work Telephone ( ) _____

- ☐ Ok, to leave a detailed message
- ☐ Leave a message with call back number only

☐ Written Communication ( ) _____

- ☐ Ok, to mail to my home address
- ☐ Ok, to mail to my work address
- ☐ Ok to fax information to ( ) _____
- ☐ Other _____

Also, to give information to spouses, significant others, and parents/children, or guardians, we must have written permission. Please indicate below with whom we may share your personal health information:

It is Ok to give information to: _____ relationship _____
_____ relationship _____
_____ relationship _____

Signature _____, Printed Name _____

Date _____ /_____ /_____

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COVID-19 Questionnaire

1. I am unaware of being a possible carrier or infected: I confirm that I have not tested positive for COVID-19 in the last 30 days and that I am not presenting with any of the following symptoms of COVID-19: A. Fever of 100.5 degrees Fahrenheit or 37 degrees Celsius or higher B. Shortness of breath C. Dry cough D. Runny nose E. Sore throat. F. Diminished sense of taste and smell

___ (initial)

2. Contact with infected: I confirm that I have not knowingly been in close contact defined as 6 feet or less for a duration of fifteen minutes or more with someone who has tested positive for COVID-19 in the last 14 days or with anyone that has had the above stated symptoms in the last 14 days. ___ (initial)

3. 5. Public travel: I confirm that I have not traveled outside of the United States in the past 14 days. I confirm that I have not traveled domestically by commercial airline, bus, or train within the last 14 days. ___ (initial)

4. I understand that air travel significantly increases my risk of contracting and transmitting the covid-19 virus. And the CDC recommends social distancing of at least six feet for a period of 14 days to anyone who has recently traveled. ___ (initial)

Printed Name: _____ Date of Birth: _____

Signature: _____ Todays Date: _____