Anne Swedlund M.D 932 State Road Second Floor

Princeton NJ 08540

Phone 609-497-2900 Fax 609-497-2910

Patient Questionnaire

(Sorry,even if I already know you I have to get all this information for new chart here)

General Information

Name______________________

Address____________________

Phone number_______________

Occupation_________________

Date of Birth ___/___/_____

Age________Sex______

Email______________________

Marital status______________

Height______ft_______inches____

Current Weight_______pounds

Internist__________________

Current Medications

Name	Dose	Reason for med

Medication allergies:_____________________________________

Food allergies:_________________________________

Iodine allergy: Yes No

Anesthesia problems in the past:_________________________

Sleep apnea: Yes No

Surgeries:

	Approximate date
__________________	______
__________________	______
__________________	______
__________________	______

Family history

Mother__________________________

Father____________________________

Brothers/sisters____________________________

Maternal grandparents_______________________

Paternal grandparents______________________

Aunts and uncles____________________

Do you smoke Yes No
Ifso how many packs per day___--how many years____
Alcohol:How many drinks per week_______

Review of your symptoms—please circle your response
Hematology history:
Any bleeding problems: Yes No Platelet problems:Yes No On Coumadin: Yes No
Any problems with excessive clotting: Yes No

Respiratory history:
Shortness of breath with exercise: Yes No
Asthma: Yes No
COPD: Yes No
Emphysema: Yes No

Cardiac history:
Angina/ chest pain: Yes No
Heart attacks: Yes No
Atrial fibrillation: Yes No
Heart valve problems: Yes No

Gastrointestinal history:
Reflux/heartburn: Yes No
Ulcers: Yes No
Colonic polyps: Yes No
Colitis: Yes No

Endocrine history:
Thyroid disease: Yes No
Diabetes: Yes No

Neurologic history:
Stroke/TIA: Yes No
Seizures: Yes No

Any other information you want me to know: