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GENERAL HEALTH QUESTIONNAIRE

Please complete the following so that we may better serve you:

Any serious medical problems? _____

Do you have a family doctor or an internist? _____ Who? _____

May I communicate with your doctor about you? _____ Any hospitalizations? _____

Date _____ Reason _____

Date _____ Reason _____

Any allergies? _____

What medications are you on now? Include over-the-counter medicines and herbal remedies. _____

Recreational drugs? _____ Do you drink alcohol? _____

Do you use nicotine/smoke cigarettes? _____ Do you use caffeine? _____

Do you have a history of: **(PLEASE MARK YES OR NO FOR EACH ONE)**

	YES	NO		YES	NO
Heart disease	_____	_____	Muscle and joint problems	_____	_____
High blood pressure	_____	_____	Eyesight problems	_____	_____
Respiratory / lung problems	_____	_____	Hearing problems	_____	_____
Stomachaches	_____	_____	Loss of consciousness	_____	_____
Indigestion	_____	_____	Severe headaches	_____	_____
Irritable bowel syndrome	_____	_____	Seizures	_____	_____
Dieting frequently	_____	_____	Being knocked unconscious	_____	_____
Diarrhea	_____	_____	Weight concerns	_____	_____
Constipation	_____	_____	Urinary problems	_____	_____
Menstrual problems:	_____	_____	Thyroid problems	_____	_____
			Diabetes	_____	_____

Print Name _____ Signature _____

Date: _____