Dr. E. Rosanne Diehl

600 North Highway 25, Travelers Rest, SC 29690
Phone: 864-834-6652

Dr. Diehl Will Respond Fastest if you
FAX THESE PAGES TO
864-834-6654

CONFIDENTIAL PATIENT QUESTIONNAIRE

Complete legal name (as you would like us to use it):
____

Date of birth:_______________________ SSN: need it to order your blood work: _____________________

At what number should we call you? ___________________ Email address: ___________________________

Mailing address, including street address, city, state, and zip code:

____

Employer or business name and address (optional):____

Do you have health insurance that you would like to use for blood work ? □Yes □No.

Name of Insurance Company: ____

We send you with a lab requisition to go to whichever facility your insurance tells you is "IN-NETWORK". Therefore, that facility draws your blood, and bills your insurance directly, and we aren't involved financially in that matter. However, because blood tests are expensive and Labs (not us!) charge up to $2000.00 for thyroid tests alone, please be sure about your insurance coverage. If your insurance covers only a small fraction, we have better options for you! PLEASE BE CERTAIN, or we will waste valuable time at your initial appointment calling your insurance company instead of focusing on you.

Call your insurance company NOW and ask these questions and get the answers on paper:
1. Get the name of the contact person with whom you speak.
2. Ask "What blood drawing lab is considered "in-network"? We have to have this information before we can schedule you. Indicate the In-Network Labs:
□ LabCorp □ LabOne □Quest _______________other____

3. "What percentage of blood work is covered if an out-of-network M.D. orders the blood work, and the blood is drawn at the in-network lab"?

4. Do I have a deductible applied to blood draw?

"I understand that my credit card will be charged a non-refundable administrative fee of $25.00 at the time I schedule my initial appointment. This fee is non-refundable and does not apply as a credit to any office visit or phone consultation. By signing below, I agree to this policy".

Legal Name Printed: ________________________________ Signature________________________ Date: ________

Credit Card number: ____

Expiration date:________________________ 3 digit code________________________

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To help us serve you better, please let us know how you heard about us:

□Google Ads □Media □Website □Friend □Relative

Are you currently on any sort of disability? □Yes □No
Are you considering disability due to your health situation? □Yes □No.

Are you currently a cigarette smoker? □Yes □No.
If Yes: WE WILL BE HAPPY TO SEE YOU AFTER YOU HAVE QUIT SMOKING CIGARETTES.

Are you currently involved in any medico-legal litigation, such as regarding a car accident, etc? □Y □N

Do you have a Living Will, or Advance Directives? □Y □N

What health goals would you like us to address? List in order of priority. To better assist you in reaching your health goals please DON'T LEAVE THE FOLLOWING SECTION BLANK!
If you are consulting us to lose weight, please understand that we do not under any circumstances prescribe weight-loss medications.

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________

What "diagnosis" have you been given? (Example: hepatitis B or C, cancer, high blood pressure, lupus, chronic fatigue, fibromyalgia, thyroid disorder, celiac disease, irritable bowel or spastic colon; arthritis, etc.)

1. ________________ 6. ________________
2. ________________ 7. ________________
3. ________________ 8. ________________
4. ________________ 9. ________________
5. ________________ 10. ________________

Have you ever had cancer? □Y □N Have you ever had Hepatitis B or Hepatitis C? □Y □N

Please list medications, both prescription and over-the-counter: use the back of this page if necessary→

Name of Medication	Strength (mg, ucg)	How often do you take?

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Circle the drug if you have ever taken it:
lorazepam (Ativan); Diazepam (Valium), clonazepam (Klonopin), IVIG (intravenous IG-G), oxycodone, hydrocodone.

Please list your dietary supplements, including herbs and vitamins and bring bottles to us.
(You can list additional supplements on the back of this page)

____
____
____
____
____
____
____
____

Do you have any allergies to medications? Please list each medicine, and what reaction it caused, below. BE SPECIFIC when you can, please. EG: "Penicillin caused me an itchy rash".

☐ Penicillin ☐ Amoxicillin ☐ Augmentin (amoxicillin/clavulanate) ☐ Sulfa ☐ Cephalosporins (keflex, cephalexin, Omnicef, etc) ☐ Lidocaine/Novocaine ☐ Other Medications:_________________________

Eggs ☐ ☐Peanuts ☐Wheat ☐Latex ☐ Bandage adhesives
Describe the reaction you had:____

Surgical History

Please list all surgeries, including biopsies, and the diagnosis:

1. ____
2. ____
3. ____
4. ____
5. ____
6. Have you had a hysterectomy? ______________ Do you still have ovaries? ☐Y ☐N
   Did you have cancer? ☐Y ☐N What type of cancer? ___________________________________
7. What year did you have colonoscopy?______________Were polyps detected? ☐Y ☐N
8. Have you had EGD (upper endoscopy of the stomach), ☐Y ☐N If Yes, what year?_____________________
9. What surgery, if any, have you had for excision of a cancer? ____

Social History

In which state were you born (if International, please list country, etc.)____________________________________
Last educational level completed ____
If you have a degree, in what discipline is/are your degrees
____
Marital status (optional) ______________ Religious preference (optional) ________________________________
Present occupation ____
Previous occupations ____
Military service (dates) ______________ Branch ____
Do you suspect exposure to anything "toxic" (examples: lead or mercury, asbestos, benzene, silicone, etc.) and if so, to which agents were you exposed____
Where have you traveled outside the USA and Canada, in the past 2 years only? ___________________________

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Lifestyle Habits

What type exercise do you perform: ____
How often do you exercise ________________________ How many minutes each time ____________________
Are you exposed to second hand tobacco smoke? ____
Did you ever smoke cigarettes, cigars or a pipe? □Y □N If yes, how many total years did you smoke?_______
How many cigarettes daily did you smoke?________________What year did you quit?_____________________
Are you smoking cigarettes now?_____Do you use smokeless tobacco: □Y □N
How many sodas do you drink a day: ____
Check whichever you use: □ sugar □ diet □ caffeinated □ decaffeinated
□cans?____________bottles?___________________________________
How many cups of caffeinated coffee do you drink daily?________________
How many cups of caffeinated tea daily______________________________

Which sweeteners do you use? Please circle: Agave Honey Stevia Sugar Splenda Raw sugar Aspartame/NutraSweet Sorbitol
What alcoholic beverage do you enjoy (beer, wine, liquor, etc.): ______________________________
How often do you drink beer/wine/liquor? ____

Preventive Healthcare:

What year was your last complete physical exam_______Breast exam (men, too) __________________________
Last Pap smear__________Last testicular exam__________Last rectal exam _____________________________

List the most recent year for each test below.
If you had CT, ultrasound, MRI, list what body part (CT of head, etc.):

Blood count:	Flu shot:	Mammogram:
Bone density:	Glucose test:	PSA Prostate test:
CT scan (of what?) and year	HIV (AIDS) test:	Pneumonia vaccine:
Cardiac catheter:	Helicobacter test for GERD?	Homocysteine:
Chest X-Ray:	Hepatitis A vaccine:	C-Reactive Protein:
Cholesterol:	Hepatitis B vaccine:	Thyroid test:
Sleep Apnea test	Kidney test:	Tetanus booster:
EEG (brain)	Liver test:	Treadmill test:
EK G(heart):	Lyme disease test:	Ultrasound (which body part):
EGD (stomach scope):	MRI (body part):	Other:

Family History:

Mother:
If living, how old is she?_____________Has she had cancer? □Y □N
At what age was cancer diagnosed ________________ What type of Cancer?______________________________
Health problems ____
If deceased, age at death __________________ Cause of death ______________________________________

Father:
If living how old is he? _____ Has he had cancer? □Y □N At what age?____________________________
Type of Cancer? ____
Health problems:____
If deceased, age at death __________ Cause of death ______________________________________

Sisters:
How many _____________ How many living _____ Their ages ___________________________________

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Please fill out for each sister. If deceased, indicate cause and AGE of death, please.
Age _____ Health problems ____
Age _____ Health problems ____
Age _____ Health problems ____
Age______Health problems____
Age______Health problems____

Brothers:
How many _____ How many living _____ Their ages ____

Please fill out for each brother. If deceased, indicate cause and AGE of death, please.
Age _____ Health problems ____
Age _____ Health problems ____
Age _____ Health problems ____
Age______ Health problems ____
Age______ Health problems ____

Children:
How many _____ How many living _____ Their ages ____
Please fill out for each child. If any are deceased, please indicate the cause of their death.
Age______ Health problems____
Age _____ Health problems ____
Age _____ Health problems ____
Age _____ Health problems ____
Age______Health problems____
Age______Health problems____

In the next sections, please check all that apply, and add anything else:

General Endocrinology

□ Unintended weight loss
□ Frequent thirst
Weight now:___________________
□ Unintended weight gain
How much have you gained________
□ Chills
□ Fever
□ Feel hot when others aren't
□ Feel cold when others aren't
□ Night sweats
□ Loss of appetite
□ Trouble falling asleep
□ Trouble staying asleep
□ Fatigue
□ Weakness in general
□ Muscle twitching and/or muscle cramping? ____
□ Constipation
□ Have you lost height
□ Rash anywhere
Other Concerns: ____

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Integument (Skin/Hair/Nails)
- ☐ Hair loss, head
- ☐ Hair loss, legs/arms/genital
- ☐ Itching after hot shower
- ☐ Psoriasis
- ☐ Melanoma
- ☐ Basal cell cancer
- ☐ Squamous cell cancer
- ☐ Pitting in nails
- ☐ Cold sores
- ☐ Eczema
- ☐ Shingles/Zoster
- ☐ Ridging in nails

Lymphatics
- ☐ Ever had lymphoma? If yes, was it Hodgkin's or non-Hodgkin's
- ☐ Spleen removed? Why ____________________________
- ☐ Lymph node biopsy. Result ____________________________
- ☐ Lymph nodes ever removed ☐Y ☐N
- ☐ Any currently tender or swollen lymph glands?
- ☐ Any concerns about HIV exposure

Head
- ☐ Headaches
- ☐ Did you have CT or MRI? If yes, please get results.
- ☐ Loss of consciousness
- ☐ Dizziness
- ☐ Facial pain
- ☐ Feeling of room moving
- ☐ Pain at temples
- ☐ Surgeries

Ears
- ☐ Ear infection now
- ☐ Tubes in ears
- ☐ Drainage
- ☐ Hearing loss
- ☐ Ringing
- ☐ Buzzing
- ☐ Deafness in relatives other than elderly
- ☐ Meniere's Disease

Throat
- ☐Strep recently
- ☐Difficulty swallowing:
- ☐Painful swallowing
- ☐Hoarseness
- ☐Surgery
- ☐Bleeding gums
- ☐ Sores/Ulcers

Eyes
- ☐ See floaters
- ☐ See flashers
- ☐ Dry eyes
- ☐ Double vision
- ☐ Light causes eye pain
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Loss of vision
- ☐ Drainage from eyes
- ☐ Styes

Nose
- ☐ Broken
- ☐ Bloody
- ☐ Drainage
- ☐ Polyps
- ☐ Stuffy
- ☐ Sneeze a lot
- ☐ Surgery:
  - ☐Septoplasty
  - ☐Rhinoplasty

Neck
- ☐ Injuries
- ☐ Pain
- ☐ Enlarged thyroid

Heart

Which Cardiologist have you seen?____________________________
Chest pain NOW? _____Site of pain (left chest, beneath nipple, etc.)____________________________
Do you have coronary artery disease ____________________________
Have you had a heart attack ____________________________
Have you had any heart tests (EKG, exercise treadmill test, ultrasound)____________________________
During what activity does the pain occur ____________________________
Does the pain ever occur during sexual activity ____________________________
How intense is the pain ("1" is mild, "10" severe) ____________________________
Where exactly is the pain located ____________________________
Does the pain travel anywhere else (down the left arm, etc.) ____________________________

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How many minutes does the pain last ____
What makes the pain better (resting, sitting up, lying down, belching, etc.)________________________________
Do you have a heart murmur ____
What have you been told is the cause ____
Have you ever had an infection of a heart valve (endocarditis) __________________________________
Have you ever had a viral infection of the heart _______________________________________
Have you ever had rheumatic fever ____
Have you ever had Atrial Fibrillation ____
Have you ever had an abnormal heart rhythm ____
Do you have palpitations ____
Are you ever short of breath _____ During what activity ______________________________________
Have you ever had high blood pressure _____ How many years ________________________________
Have you ever had high cholesterol _____ How many years ___________________________________
Have you ever had leg pain/cramping with exercise, or after exercise _____________________________
Describe the exercise and the pain ____

Lungs

What lung specialist have you seen ____
Have you had tuberculosis?
Have you ever smoked cigarettes _____ How many years? _____________________________________
How many packs per day _____ What year did you stop ______________________ Still smoking?_________
When was your last chest X-Ray _____Was it normal?____
Do you have asthma _____ Were you ever hospitalized because of asthma ________________________
Were you ever on a ventilator in the hospital ____
Do you have a chronic cough ____
When is your cough worse (at night, after eating, etc.) ______________________________________
Do you ever cough up blood or dark-looking particles _______________________________________
Are you short of breath _____ During what activities ____
____
Are you short of breath when resting ____
Have you ever had blood clots in the lungs (pulmonary emboli) _______________________________
Have you ever had pneumonia ____
Did infection do any damage to your lungs ____
Have you ever been told you have emphysema (COPD) _______________________________________
Have you ever lived in the same household with someone who has tuberculosis ____________________
Have you ever been treated to prevent tuberculosis, or for TB? ________________________________
Have you ever tested positive to a skin prick TB test? _____________________________________
Ever had a lung collapse ____
Does breathing cause you pain? ____
Ever had bronchoscopy?____

GI/Abdomen

Name of your GI Doctor____
Have you ever had a scope put down your throat to look into your stomach (EGD) ____________________
Were you told you had gastritis, ulcer, reflux, GERD, hiatal hernia? (circle which) ___________________
Have you ever had a stomach or duodenal ulcer ____
Were you ever tested or treated for Helicobacter pylori infection ☐Yes ☐ No
If yes, what medications did you receive, and for how long ____________________________________
____

Any difficulty swallowing liquids ☐Yes ☐ No Feel like solid foods get stuck? ☐ Yes ☐ No

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Have you been diagnosed with a hiatal hernia____
Do you have trouble with esophageal stricture □Yes □ No
Have you had a scope inserted into the rectum or colon? □Yes □ No
Have you ever had colon polyps? □Yes □ No
Have you had Hepatitis A? Have you had Hepatitis B? Hep C? (Please circle)
Have you ever been treated with interferon?____
Do you have any abdominal pain ____
Where is it located (upper, lower, right, left) ____
Do you have any nausea ____
Do you have any vomiting ____
Are you vomiting up blood or "coffee-ground" vomit ____
Does having a BM make the pain better ____
How often do you have BM's (circle one): □ Daily □Several times a day □ Every other day □ Every 2 days
Your BM's are (circle all that apply): □formed □ loose □pencil-thin □mucus-like; □bloody on surface □blackish
Does having a BM cause rectal pain ____
Do you take a stool softener (such as Colace or Phillips Milk of Magnesia), a laxative or use glycerin suppositories? If yes please list: ____
Do you have problems with hemorrhoids ____
How many 8-oz glasses of water do you drink a day ____
Do you have problems with bloating _____ Belching _____ Passing gas frequently _______________________
Have you ever had irritable bowel syndrome ("spastic colon") ____
Have you ever had ulcerative colitis or Crohn's Disease ____
Have you ever had "yellow-jaundice" ____

WOMEN ONLY (all information is CONFIDENTIAL)

Name of your gynecologist ____
Are you currently sexually active? □Yes □ No
What is your type of contraception? (vasectomy, birth control pills, diaphragm, IUD, foam and condoms, etc.)
____
Total number of pregnancies, including miscarriages/abortions ____
Total number of full-term babies _____ Total number of living children ____
Have you ever had an abnormal pap smear _____ What year ____
How was it treated? □Vaginal cream □Repeated and normal □Cryotherapy □LEEP procedure □Surgery
When was your last normal pap smear ____
Who performed it ____
Your age when you had your first period _____ Age of menopause, if applicable ___________________________
Are your periods regular? □Yes □ No How many days from onset to onset ___________________________
How many days does your period usually last?____
Do you have pain during your periods _____ Number of pads or tampons per day ___________________________
Have you ever taken birth control pills? □Yes □ No For how many years ___________________________
How many years have you taken synthetic hormones (Premarin, PremPhase, PremPro, Menest, etc)____________
Have you ever had an abdominal ultrasound, or a vaginal ultrasound ____
What year did you have the ultrasound _____ Why ____
____
Have you ever had endometriosis? □Yes □ No How was it treated ____
____
Have you ever had uterine fibroids? □Yes □ No Ovarian cysts? □Yes □ No
How were they treated ____
____

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Have you ever had cervical, uterine, or ovarian cance? ☐Yes ☐ No
How was it treated ____
____
Have you ever had a biopsy of the uterus or cervix? ☐Yes ☐ No
Have you ever had dysfunctional uterine bleeding? ☐Yes ☐ No
Do you have any pain during sexual activity? ☐Yes ☐ No
Where is the pain located ____
Are there any female cancers in your mother, sisters, or close relatives ____________________
Have you ever had a breast lump ___________________________________
Have you ever had a lump aspirated with a needle ______________________
Have you ever had a breast biopsy ☐Yes ☐ No When ____________________
What were the results ____
Do you examine your own breasts monthly? ☐Yes ☐ No
Would you like us to instruct you in this? _☐Yes ☐ No
Have you ever had bacterial vaginosis, hlamydia, gonorrhea or yeast infection? (Circle which, please).
Have you ever had genital warts? ☐Yes ☐ No
Have you ever had herpes ☐Yes ☐ No
Have you ever been exposed to syphilis ☐Yes ☐ No

Urologic: (Please select and answer the appropriate questions related to your gender)

Name of your urologist ____
Have you ever had an undescended testicle ___________________________
Have you ever had testicular cancer ________________________________
Have you ever had a testicular ultrasound ____________________________
Have you had a transrectal prostate ultrasound_________________________
Do you have any difficulty with urination (circle one): difficulty starting – pain – decreased stream – frequency at night
How many times do you have to get up to urinate at night ______________________
Have you ever had a urinary tract infection _____ Was the urine ever cultured ______________
Have you ever had an abnormal PSA (prostate blood test) _____ When __________________
Have you ever had a biopsy of prostate ☐Yes ☐ No
Have you ever had prostate cancer ☐Yes ☐ No
Have you ever had gonorrhea (GC, clap), syphilis, genital warts, or genital herpes? (circle appropriate)
Have you ever had a positive VDRL or RPR test (for syphilis)______________________
Do you have any pain during ejaculation _______________________________
Have you ever had urinary infection __________________________________
Which specific infection did you have? ☐bladder ☐urethra ☐kidney ________________
Did anyone culture your urine to identify which bacterial infection you had?__
What antibiotic has been used on this? ☐TMP-SMX (Bactrim) ☐Cipro ☐Amoxil ☐Macrobid ☐other___________
Have you ever had kidney stones ____________________________________
Were the kidney stones discovered incidentally, or did you have pain and/or infection from them? ___________
____
How were they treated (pain relief only; basket retrieval; surgical excision, etc.):____________________
____
Were the stones sent for analysis, to see what they were composed of?(calcium oxalate, etc.):______________
____
Do you have any problem with leakage of urine (dribbling) ☐Yes ☐ No
Do you have any burning with urination ? ☐Yes ☐ No
Do you have any flank, side, or lower back pain ?_☐Yes ☐ No
Do you feel you are emptying your bladder completely ? ☐Yes ☐ No
Do you have any trouble initiating urination ___________________________

Do you have any problem with frequent urination ______________________________
Have you ever seen blood in your urine ______________________________
Did you have a cystoscopy _____ IVP _____ CT ______________________________

Neurologic:

Name of your Neurologist: ______________________________
Have you ever lost consciousness? □Yes □ No Describe what happened prior ____________________
____
Have you ever had a head injury ? □Yes □ No When: ______________________________
Have you had any head surgery ? □Yes □ No
Have you ever had an aneurysm of the brain? □Yes □ No
Has anyone in your family had aneurysm in the brain? □Yes □ No Did they have surgery for it? □Yes □ No
Have you ever had a stroke? □Yes □ No If yes, describe : ______________________________
____
Have you ever had a seizure? □Yes □ No
Have you ever been told you have MS (multiple sclerosis)? □Yes □ No
Do you have any dizziness? □Yes □ No _____ Vertigo _____ Numbness _____ Tingling
Do you have any trouble with memory ? □Yes □ No
Do you have difficulty concentrating ? □Yes □ No
Have you ever felt depressed? □Yes □ No
Have you been treated for depression? □Yes □ No
Have you been hospitalized for depression (all info is confidential)______________________________
____
Do you have headaches? □Yes □ No How often : ______________________________
How were these headaches explained to you? ______________________________
____
Do you have any difficulty speaking ? □Yes □ No Walking : □Yes □ No
Do you have any difficulty seeing ? □Yes □ No Swallowing: □Yes □ No
Do you have any loss of taste or smell ? □Yes □ No
Do you have color blindness? □Yes □ No
Do you have any numbness or tingling in the hands or feet? □Yes □ No
Do you have any numbness or tingling in the face ? □Yes □ No
Do you have any burning sensation in the hands or feet? □Yes □ No
Do you have any difficulty with balance? □Yes □ No
Do you have trouble initiating walking ? □Yes □ No
Do you have any tremors ? □Yes □ No
Anyone in your family with Lou Gehrig's Disease (ALS), amyotrophic lateral sclerosis (ALS), prion disease, supranuclear palsy, etc.? Circle if so. Add if necessary: ______________________________

Rheumatological/Musculoskeletal:

Name of your rheumatologist: ______________________________
Do you have osteoarthritis? □Yes □ No Rheumatoid arthritis?_ □Yes □ No
Ever had gold injections? □Yes □ No
Ever had a joint replaced surgically, and if so, which joint? ______________________________
What joints are affected worst ______________________________
Does your pain awaken you at night ______________________________
Do you have excessive hair loss ______________________________
Do your jaws tire out when chewing food ______________________________
Do you have weakness _____ Where ______________________________

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Do you have trouble getting out of a chair ____________________
Do you have trouble climbing stairs ____________________
Which of your joints is/are red, swollen, or painful ____________________
Does your morning stiffness or pain last longer than one half hour ____________________
Does exercise worsen your pain ____________________
Do you have leg cramps ____________________
Have you ever had gout ____________________
How was it treated ____________________
Do you have any other arthritis related to psoriasis, etc. ____________________
Have you ever had a positive ANA test (anti-nuclear-antibody) ____________________
Have you ever had a positive RF test (rheumatoid factor) ____________________
Have you ever had a positive ASO test (anti-strepto-lysin) ____________________
Have you ever been diagnosed with rheumatoid arthritis, systemic lupus erythematosis, scleroderma, Sjogren's syndrome, or any other autoimmune disorder ____________________
Have you ever been diagnosed with fibromyalgia ____________________
Did you have muscle biopsy ____________________
Do you suffer from dry eyes _____ Dry mouth _____ Painful bluish fingers or toes ____________________
Do you have trouble swallowing ____________________
Do you notice any painful lumps under the skin at joints ____________________
Do you have any problems with mouth ulcers _____ Exact location in the mouth____________________

Extremities

Name of your podiatrist :____________________
Have you ever had blood clots in the legs _____ Were you hospitalized____________________
How were you treated ____________________
Do you have varicose veins _____ Feet problems ____________________
Have you had any foot surgeries ____________________

Hematologic:

Name of your Hematologist: ____________________
Your blood type is _____________ (A+, A-, B+, B-, O+, O-, AB+, AB- etc)
Have you ever had a problem with severe bleeding after a surgery or a tooth extraction, etc. ____________________
Have you ever had anemia?_________Hemophilia?__________Leukemia?_________Thalassemia_____________
Have you ever seen a blood specialist _____ Name ____________________
Have you ever had a bone marrow biopsy ____________________
Have you ever had a blood transfusion___How many units of blood______WHAT YEAR(S)_________________
Do you have any relatives with sickle cell disease, or sickle cell trait ____________________
Have you ever been told you had G6PD deficiency _____ Thalassemia ____________________
Have you ever been told you had abnormal hemoglobin ____________________
Have you ever been tested for low iron _____ Low B-12 ____________________

We will not draw blood during your appointment so you will not need to come fasting.

Please do not send us any other medical records until we request them.

Your Legal Name:___________________ **Date of Birth:** ______________________________