LINDEN MEDICAL GROUP

Ewa Czyzewski, M.D., Robert Czyzewski, M.D. & Edyta Kolbusz, APN

Clinical Questionnaire

_____ _____

Last Name First Name Date

_____

Reason for today's visit When did your present illness commenced?

Medication you presently are taking:

1. _____ 2. _____
Medication, strength, dosage Medication, strength, dosage

3. _____ 4. _____
Medication, strength, dosage Medication, strength, dosage

5. _____ 6. _____
Medication, strength, dosage Medication, strength, dosage

7. _____ 8. _____
Medication, strength, dosage Medication, strength, dosage

_____

Do you have allergies to any medication Do you have allergies to anything else, if yes, please list

_____

Do you have your Cardiologist? If yes, provide Name & Telephone Number

_____

(For female patients only) Do you have your OB-GYN? If yes, provide Name & Telephone Number

_____

Did you go to the hospital during the last two years? If yes, which hospital, dates and reason

_____

Did you have any surgery in the past? If yes, what kind