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Physician
Internal Medicine

MEDICAL HISTORY QUESTIONNAIRE

PLEASE PRINT

Name: _____
Last First Middle Initial

Today's Date: _____

Routine Physical Exam – No Complaints Age _____ Birthdate _____ Birthplace _____

Are you allergic to any medications? If so, please list medicines and reactions: _____

MEDICATIONS: Are you presently taking any medication? (Please include heart and breathing pills, laxatives, vitamins, antacids, iron pills, hormones, insulin, birth-control pills, aspirin, sedatives, and periodic injections.)

IMMUNIZATIONS: (Please give dates.) Tetanus _____ Flu _____ Polio _____ Other _____

Date and results of last Tuberculosis Skin Test: _____

Date and results of last Electrocardiogram (EKG): _____

Present Weight _____ Weight 1 year ago _____ 5 years ago _____ Most ever _____ When? _____

Have you previously been under the care of another physician for current problems? ___ If so, who? _____

Do you follow a particular diet? _____

HOSPITALIZATIONS and SURGERIES: (Including appendix, gall bladder, hysterectomy, etc.)

DATE	MEDICAL PROBLEM	DATE	MEDICAL PROBLEM

REVIEW OF RECENT SYMPTOMS (Please X any of the following symptoms you have experienced recently)

- | | | | |
|---|--|---|--|
| <p>General</p> <input type="checkbox"/> Chills or fever
<input type="checkbox"/> Unusual fatigue
<input type="checkbox"/> Sexual dissatisfaction
<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/> Change in sleep
<input type="checkbox"/> Swollen glands
<input type="checkbox"/> Weight change
<input type="checkbox"/> Change in heat & cold tolerance | <p>Breasts</p> <input type="checkbox"/> Lump
<input type="checkbox"/> Pain
<input type="checkbox"/> Discharge | <p>Urinary</p> <input type="checkbox"/> Pain or burning on urination
<input type="checkbox"/> Frequency
<input type="checkbox"/> Change in urinary stream
<input type="checkbox"/> Incontinence
<input type="checkbox"/> Penile discharge
<input type="checkbox"/> Blood in urine | <p>Mood</p> <input type="checkbox"/> Memory change
<input type="checkbox"/> Frequent crying
<input type="checkbox"/> Depression
<input type="checkbox"/> Excessive worry
<input type="checkbox"/> Tense or under stress
<input type="checkbox"/> Work or family problems
<input type="checkbox"/> Frightening thoughts
<input type="checkbox"/> Desired psychiatric help
<input type="checkbox"/> Considered suicide
<input type="checkbox"/> Paranoia |
| <p>Eyes</p> <input type="checkbox"/> Blurry vision
<input type="checkbox"/> Eye pain
<input type="checkbox"/> Double vision | <p>Heart & Lungs</p> <input type="checkbox"/> Racing or fluttering heart
<input type="checkbox"/> Chest discomfort
<input type="checkbox"/> Swollen feet or ankles
<input type="checkbox"/> Persistent cough
<input type="checkbox"/> Coughing up blood/phlegm
<input type="checkbox"/> Difficulty breathing
<input type="checkbox"/> Wheeze
<input type="checkbox"/> Shortness of breath | <p>Bones & Joints</p> <input type="checkbox"/> Painful or stiff joints
<input type="checkbox"/> Swelling of joints
<input type="checkbox"/> Back or neck pain
<input type="checkbox"/> Cramps in muscles
<input type="checkbox"/> Foot trouble
<input type="checkbox"/> History of fracture
<input type="checkbox"/> Loss of 1 1/2" height | <p>Neurologic</p> <input type="checkbox"/> Numbness or tingling
<input type="checkbox"/> Tremor
<input type="checkbox"/> Trouble walking
<input type="checkbox"/> Seizures or convulsions
<input type="checkbox"/> Frequent headache
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Fainting spells |
| <p>Ears</p> <input type="checkbox"/> Hearing loss
<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Earache | <p>Gastrointestinal</p> <input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Heartburn
<input type="checkbox"/> Nausea
<input type="checkbox"/> Vomiting
<input type="checkbox"/> Vomiting blood
<input type="checkbox"/> Constipation
<input type="checkbox"/> Loose bowels/diarrhea
<input type="checkbox"/> Bloody or black stools
<input type="checkbox"/> Change in stools
<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Abdominal pain | <p>Menstrual (women)</p> <input type="checkbox"/> Bleeding after menopause
<input type="checkbox"/> Menstrual pain
<input type="checkbox"/> Spotting
<input type="checkbox"/> Discharge
<input type="checkbox"/> Heavy bleeding
<input type="checkbox"/> Irregular bleeding | <p>Skin</p> <input type="checkbox"/> Itching
<input type="checkbox"/> Rash or hives
<input type="checkbox"/> Change in skin or mole
<input type="checkbox"/> Bed sores |
| <p>Throat</p> <input type="checkbox"/> Hoarseness
<input type="checkbox"/> Bleeding gums | | | |
| <p>Nose</p> <input type="checkbox"/> Nose bleeds
<input type="checkbox"/> Runny nose
<input type="checkbox"/> Stuffy nose | | | |

I understand the above questions, and the answers given by me are correct to the best of my knowledge and belief.

Date

Signature of Patient or Escort

Escort's Relationship to Patient

FAMILY HISTORY	IF LIVING		IF DECEASED		Has any blood relative ever had:
	Age	Health	Age at Death	Cause	
Father					<input type="checkbox"/> Cancer <input type="checkbox"/> Sugar Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Mental Illness <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Gout <input type="checkbox"/> Kidney Stone <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Blood Disease <input type="checkbox"/> Goiter <input type="checkbox"/> Stroke <input type="checkbox"/> Allergy <input type="checkbox"/> Overweight
Mother					
Brother or Sister					
1.					
2.					
3.					
4.					
5.					
Spouse					
Children					
1.					
2.					
3.					
4.					
5.					

PERSONAL HISTORY (Please circle and date those you have had)

Rheumatic Fever	_____	Urinary Tract Infection	_____	Skin Trouble	_____
Scarlet Fever	_____	Thyroid Disease	_____	Venereal Disease	_____
Heart Disease	_____	Tuberculosis	_____	Head Injury	_____
Heart Murmur	_____	Stroke	_____	Hepatitis or Yellow Jaundice	_____
High Blood Pressure	_____	Pneumonia	_____	Kidney Disease or Stones	_____
Anemia	_____	Asthma or Hay Fever	_____	Bladder or Prostate Trouble	_____
Ulcers	_____	Lung Disease	_____	Colitis or Bowel Trouble	_____
Arthritis or Rheumatism	_____	Diabetes	_____	Eye Disease	_____
Bone Disease	_____	Cancer	_____	Cholesterol Problem	_____
Gout	_____	Migraine Headaches	_____	Transfusion	_____
Liver Disease	_____	Seizures	_____	X-ray Treatment	_____
Gall Bladder Disease	_____	Nervous Breakdown	_____	Cortisone Treatment	_____

X-RAYS Have you ever had x-rays of:

	DATE	RESULT		DATE	RESULT
Chest	_____	_____	Gall Bladder	_____	_____
Stomach	_____	_____	Back	_____	_____
Colon	_____	_____	Other	_____	_____

HABITS and SOCIAL ACTIVITIES

Relationship status _____

Religious Affiliation _____ Education _____ Occupation _____

How long in this occupation? _____ Problems with job? _____

Previous Jobs _____

Where else have you lived? _____

Do you use: Cigarettes _____ packs/day Cigars Pipe Coffee _____ cups/day Tea _____ cups/day

Regular Exercise _____

Have you ever used experimental drugs? Marijuana LSD Speed Heroin Other _____

How much alcohol do you consume in one day? _____

Have you ever used alcohol or medication excessively? _____

NOTES _____

ADDRESS
