

**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><b>General</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chills or fever</li> <li><input type="checkbox"/> Unusual fatigue</li> <li><input type="checkbox"/> Sexual dissatisfaction</li> <li><input type="checkbox"/> Excessive Thirst</li> <li><input type="checkbox"/> Change in sleep</li> <li><input type="checkbox"/> Swollen glands</li> <li><input type="checkbox"/> Weight change</li> <li><input type="checkbox"/> Change in heat &amp; cold Tolerance</li> </ul> <p><b>Eyes</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Blurry vision</li> <li><input type="checkbox"/> Eye pain</li> <li><input type="checkbox"/> Double vision</li> </ul> <p><b>Ears</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Hearing loss</li> <li><input type="checkbox"/> Ringing in ears</li> <li><input type="checkbox"/> Earache</li> </ul> <p><b>Throat</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Hoarseness</li> <li><input type="checkbox"/> Bleeding gums</li> </ul> <p><b>Nose</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Nose bleeds</li> <li><input type="checkbox"/> Runny nose</li> <li><input type="checkbox"/> Stuffy nose</li> <li><input type="checkbox"/></li> </ul> | <p><b>Breasts</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Lump</li> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Discharge</li> </ul> <p><b>Heart &amp; Lungs</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Racing or fluttering heart</li> <li><input type="checkbox"/> Chest discomfort</li> <li><input type="checkbox"/> Swollen feet or ankles</li> <li><input type="checkbox"/> Persistent cough</li> <li><input type="checkbox"/> Coughing up blood/phlegm</li> <li><input type="checkbox"/> Difficulty breathing</li> <li><input type="checkbox"/> Wheeze</li> <li><input type="checkbox"/> Shortness of breath</li> </ul> <p><b>Gastrointestinal</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Difficulty swallowing</li> <li><input type="checkbox"/> Heartburn</li> <li><input type="checkbox"/> Nausea</li> <li><input type="checkbox"/> Vomiting</li> <li><input type="checkbox"/> Vomiting blood</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Loose bowels/diarrhea</li> <li><input type="checkbox"/> Bloody or black stools</li> <li><input type="checkbox"/> Change in stools</li> <li><input type="checkbox"/> Hemorrhoids</li> <li><input type="checkbox"/> Abdominal pain</li> </ul> | <p><b>Urinary</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain or burning on urination</li> <li><input type="checkbox"/> Frequency</li> <li><input type="checkbox"/> Change in urinary stream</li> <li><input type="checkbox"/> Incontinence</li> <li><input type="checkbox"/> Penile discharge</li> <li><input type="checkbox"/> Blood in urine</li> </ul> <p><b>Bones &amp; Joints</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Painful or stiff joints</li> <li><input type="checkbox"/> Swelling of joints</li> <li><input type="checkbox"/> Back or neck pain</li> <li><input type="checkbox"/> Cramps in muscles</li> <li><input type="checkbox"/> Foot trouble</li> <li><input type="checkbox"/> History of fracture</li> <li><input type="checkbox"/> Loss of 1 ½" height</li> <li><input type="checkbox"/> Family history osteoporosis</li> </ul> <p><b>Menstrual (women)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bleeding after menopause</li> <li><input type="checkbox"/> Menstrual pain</li> <li><input type="checkbox"/> Spotting</li> <li><input type="checkbox"/> Discharge</li> <li><input type="checkbox"/> Heavy bleeding</li> <li><input type="checkbox"/> Irregular bleeding</li> <li><input type="checkbox"/></li> <li><input type="checkbox"/></li> </ul> | <p><b>Mood</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Memory change</li> <li><input type="checkbox"/> Frequent crying</li> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Excessive worry</li> <li><input type="checkbox"/> Tense or under stress</li> <li><input type="checkbox"/> Work or family problems</li> <li><input type="checkbox"/> Frightening thoughts</li> <li><input type="checkbox"/> Desired psychiatric help</li> <li><input type="checkbox"/> Considered suicide</li> </ul> <p><b>Neurologic</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Paranoia</li> <li><input type="checkbox"/> Numbness or tingling</li> <li><input type="checkbox"/> Tremor</li> <li><input type="checkbox"/> Trouble walking</li> <li><input type="checkbox"/> Seizures or convulsions</li> <li><input type="checkbox"/> Frequent headache</li> <li><input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> Fainting spells</li> <li><input type="checkbox"/> Falls</li> </ul> <p><b>Skin</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Itching</li> <li><input type="checkbox"/> Rash or hives</li> <li><input type="checkbox"/> Change in skin or mole</li> <li><input type="checkbox"/> Bed sores</li> </ul> |
|---|---|---|---|

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** \_\_\_\_\_