MEDICAL HISTORY QUESTIONNAIRE

Name_____ Date _____

Date of Birth _____

Please respond to all questions. Your response will remain confidential.

Do you ***currently*** have any problems in the following areas? If YES, please provide additional information.

	YES	NO	DETAILS
GENERAL (fever, chills, sweats, weight gain or loss, fatigue, malaise, daytime sleepiness)			
EYES (poor vision, eye pain, tearing, redness, itching, double vision, sensitivity to light)			
EAR, NOSE, THROAT (hard of hearing, ear pain, stuffy nose, drainage, nosebleeds, dry mouth, sore throat, throat clearing, difficult swallowing)			
HEART AND VASCULAR (chest pain, high blood pressure, rapid pulse, irregular heart beat, leg or ankle swelling, leg pain during walking)			
BREATHING (chest congestion, cough, phlegm, wheezing, shortness of breath)			
STOMACH AND INTESTINES (nausea, vomiting, difficulties swallowing, heartburn, ulcers, stomach pain, diarrhea, constipation, blood in stools, hernia)			
KIDNEYS, **BLADDER, GENITAL** (flank pain, painful or frequent urination, incontinence, impotence, testicular pain, vaginal discharge, painful or irregular periods)			
MUSCLES, **BONES, JOINTS** (joint pain, stiffness, swelling, cramps, arthritis)			
SKIN (rash, itching, ulcers, lesions, pimples, warts, growths)			
NERVES (headache, seizures, numbness, burning pain, paralysis, tremors, difficulty walking)			
PSYCHIATRIC (depression, anxiety, memory loss, mental disturbance, suicidal ideation, paranoia)			
ENDOCRINE (diabetes, changes in tolerance of heat/cold, excessive thirst, weight gain or loss, bone problems)			
BLOOD AND LYMPH GLANDS (bleeding, bruising, blood clots, enlarged or tender glands, night sweats, anemia - low blood count)			
ALLERGIES AND INFECTIONS (hay fever, food allergy, latex allergy, hives, lupus, rheumatoid arthritis, frequent infections, HIV)			
HEALTH SCREENING	**YES**	**NO**	**DATE / YEAR**
Colonoscopy			
Mammogram			
Pap Smear			
Last OB GYN Exam			
Last menstrual period			
Bone density (DEXA) scan			
Prostate cancer screening			
Skin cancer screening			

CURRENT OR PAST DISEASES	POSITIVE (+)		POSITIVE (+)
Allergies		Anemia	
Anxiety		Arthritis (degenerative)	
Arthritis (rheumatoid)		Asthma	
Atrial fibrillation		Back pain (chronic)	
Blood clot		Cancer-breast	
Cancer-colon, stomach, intestine		Cancer – lung	
Cancer – prostate		Cancer – skin	
Cancer – uterus or ovary		Cholesterol high	
COPD (emphysema)		Coronary artery disease	
Depression		Diabetes (Type 1)	
Diabetes (Type 2)		Esophageal reflux	
Gallstones		Glaucoma	
Gout		Hearing Loss	
Heart attack		Heart failure	
Heart valve disease		High blood pressure	
Irregular heart beat		Irritable bowel syndrome	
Kidney disease		Kidney stone	
Liver disease		Migraine headache	
Osteopenia or osteoporosis		Oxygen use (chronic)	
Pancreatitis		Prostate enlarged	
Rheumatic fever		Seizure disorder (epilepsy)	
Sinusitis (chronic)		Skin disorder	
Sleep apnea		Stomach ulcer	
Stroke		Testosterone low	
Thyroid (low)		Visual impairment	
CURRENT OR PAST DISEASES NOT LISTED ABOVE:			

SURGERY HISTORY	DATE/YEAR		DATE/YEAR
Aortic aneurysm repair		Aortic valve replacement	
Appendectomy		Carotid artery surgery	
Cholecystectomy (gallbladder removal)		Colon Surgery	
Coronary artery bypass graft		Heart stent	
Hernia repair		Hip replacement	
Knee replacement		Mitral valve surgery (replacement)	
Pacemaker implantation		Prostatectomy (prostate removal)	
Spine surgery		Thyroid surgery	
Tonsillectomy			
SURGERY HISTORY NOT LISTED ABOVE:			

FAMILY HISTORY - Has any of your family members had these diseases? IF SO, please indicate which family member(s) – M = mother, F = father, C = child, S = sibling, GM = grandmother, GF = grandfather, U = uncle, A = aunt			
Allergies		Anemia	
Anxiety		Arthritis (degenerative)	
Arthritis (rheumatoid)		Asthma	
Atrial fibrillation		Back pain (chronic)	
Blood clot		Cancer-breast	
Cancer-colon, stomach, intestine		Cancer – lung	
Cancer – prostate		Cancer – skin	

Cancer – uterus or ovary		Cholesterol high	
COPD (emphysema)		Coronary artery disease	
Depression		Diabetes (Type 1)	
Diabetes (Type 2)		Esophageal reflux	
Gallstones		Glaucoma	
Gout		Hearing Loss	
Heart attack		Heart failure	
Heart valve disease		High blood pressure	
Irregular heart beat		Irritable bowel syndrome	
Kidney disease		Kidney stone	
Liver disease		Migraine headache	
Osteopenia or osteoporosis		Oxygen use (chronic)	
Pancreatitis		Prostate enlarged	
Rheumatic fever		Seizure disorder (epilepsy)	
Sinusitis (chronic)		Skin disorder	
Sleep apnea		Stomach ulcer	
Stroke		Testosterone low	
Thyroid (low)		Visual impairment	

FAMILY HISTORY NOT LISTED ABOVE:

IMMUNIZATION HISTORY	**YEAR**
Chicken Pox (varicella)	
Influenza H1N1	
Hepatitis A	
Hepatitis B	
Human Papilloma Virus (HPV)	
Influenza (seasonal)	
Meningococcus	
MMR (measles, mumps, rubella)	
Pneumococcus (Pneumovax)	
Polio (Salk vaccine or oral polio vaccine)	
PPD	
Tdap (tetanus, diphtheria, pertussis – adult)	
Tetanus	
Typhoid	
Zoster (Shingles)	

HABITS

SMOKING Do you ***currently*** smoke ? ❒ NO ❒ YES – If yes, how many packs per day? _____

Have you ***ever*** smoked ? ❒ NO ❒ YES – If yes, when did you quit? _____

ALCOHOL Do you drink alcohol ? ❒ NO ❒ YES ❒ Not currently, but I used to drink in the past.

If yes, what kind? _____ How many drinks per week? _____

RECREATIONAL DRUGS Do you ***currently*** use any recreational drugs or (medical) marijuana ?

❒ NO ❒ YES – If yes, what kind ? _____

Have you ***ever*** used injectable drugs or cocaine ? ❒ NO ❒ YES – If yes, what kind ? _____

MEDICATIONS

Have you ever had an ALLERGIC or severe adverse REACTION to any medication ?

❒ **NO** ❒ **YES** – If yes, please list medication and type of reaction:

Medication name	Type of reaction	Approx. date/year

Please mark any of the following OVER-THE-COUNTER MEDICATIONS that you use REGULARLY (i.e. at least 2x/week):

	YES		**YES**
Aspirin		Tylenol (acetaminophen)	
Motrin (ibuprofen)		Aleve (naproxen)	
Excedrin Migraine		Laxative (Colace, Dulcolax)	
Antacid (e.g. Tums, Maalox, Zantac, Pepcid)		Prilosec OTC, Prevacid OTC, Zegerid	
Allergy (antihistamine) medication, e.g. Benadryl, Claritin, Zyrtec, Allegra Allergy			
Sudafed (pseudoephedrine)			

Do you take any vitamins, minerals or other supplements ?

	YES		**YES**		**YES**
Calcium		Vitamin D		Multivitamin	
Vitamin A (or beta-carotene)		Vitamin B-12		Vitamin C	
Vitamin E		Folic acid		Fiber (e.g. Metamucil)	
Other:					

Please list all prescription medications that you take:

Medication name	Strength or Dose	Frequency or time taken