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Patient's Medical History Questionnaire

Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_  
Local Address: \_\_\_\_\_  
Permanent(Summer) Address, if different than above \_\_\_\_\_  
\_\_\_\_\_  
Local Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Work Phone # \_\_\_\_\_ Summer Phone #(if different) \_\_\_\_\_  
Email address \_\_\_\_\_

Were you referred by a physician? \_\_\_\_\_ Referring Physician Name: \_\_\_\_\_  
Referring Physician Phone # \_\_\_\_\_ Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
If unemployed, last date of employment \_\_\_\_\_ Are you disabled: \_\_\_\_\_  
Spouse's occupation \_\_\_\_\_ Work Phone # \_\_\_\_\_

Number of Children \_\_\_\_\_ Ages \_\_\_\_\_

What is the chief problem that brings you to my office? \_\_\_\_\_

How long have you had the problem? \_\_\_\_\_

What do you think might be causing it? \_\_\_\_\_

***Past Medical History***

**Hospitalizations:**

Year	Diagnosis	Operation (if any)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Other Serious Illnesses:**

Year	Diagnosis
_____	_____
_____	_____
_____	_____

**Allergies:** List all medicines and other substances to which you are allergic

\_\_\_\_\_  
\_\_\_\_\_

**Medicines:** List all medicines that you have been taking recently. (Please include all vitamins and non-prescription medicines as well as prescribed medicines).

**Please bring all medications with you.**

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

**Immunizations:**

Pneumonia Vaccine \_\_\_\_\_ (date) Tetanus \_\_\_\_\_ (date)

**History:** List parents and all brother and sisters, if deceased, please list age and cause of death.

Living? Current Age or date of death

State of Health or Cause of Death

Mother \_\_\_\_\_  
Father \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there a family history of any of the following in a blood relative? Please check.

\_\_\_\_ alcoholism    \_\_\_\_ high blood pressure    \_\_\_\_ diabetes    \_\_\_\_ cholesterol problems  
\_\_\_\_ colon cancer    \_\_\_\_ breast cancer    \_\_\_\_ prostate cancer    \_\_\_\_ other cancer  
\_\_\_\_ stroke    \_\_\_\_ kidney stones or failure    \_\_\_\_ heart attack before 60    \_\_\_\_ depression

**Personal Habits:**

Tobacco (type and amount per day) \_\_\_\_\_  
If not smoking now, have you smoked in the past? \_\_\_\_\_  
Alcohol (amount per day or week) \_\_\_\_\_  
Have you had a problem with alcohol? \_\_\_\_\_  
Coffee, Tea, and Cola Beverages (cups per day) \_\_\_\_\_  
Special Diet \_\_\_\_\_

**Activity Level:**

Independent with all daily activities	_____ Yes	_____ No	
Requires special assistance or equipment	_____ Yes	_____ No	Explain _____
Completely Dependent	_____ Yes	_____ No	

Do you have any of the following?

Yes

No

		Yes	No
1	Recent weight gain? ( _____ pounds)		
2	Recent weight loss? ( _____ pounds)		
3	Fever or soaking sweats at night?		
4	Fatigue?		
5	Weakness or numbness of arms or legs?		
6	Headaches more than once or twice a week?		
7	Difficulty walking?		
8	Loss of consciousness or convulsions?		
9	Do friends or family ask you to repeat what you say?		
10	Do you have difficulty completing your thoughts?		
11	Problem with vision that is not corrected with glasses?		
12	Change in hearing?		
13	Ringing in your ears?		
14	Dizziness?		
15	Frequent or severe nosebleeds?		
16	Trouble chewing or swallowing?		
17	Sore tongue or mouth?		
18	Neck pain or stiffness?		
19	Daily cough?		
20	Short of breath after walking up two flights of stairs?		
21	Short of breath when just sitting or lying down?		
22	Discomfort in the chest?		
23	Swelling of the ankles everyday?		
24	Pain in the legs while walking?		
25	High blood pressure?		
26	Abdominal pain?		
27	Frequent heartburn or indigestion?		
28	Change in bowel movements?		
29	Black or bloody bowel movements?		
30	Recent change in your appetite?(explain)		
31	Nausea, vomiting, diarrhea for more than 5 days?		
32	Bloody or otherwise unusual appearing urine?		
33	Difficulty urinating?		
34	Do you lose control of urine at times?		
35	Awaken at night more than once to urinate?		
36	Any skin problems at this time?		
37	Persistent pain in joints?		

		Yes	No
38	Back pain?		
39	Do you enjoy your work?		
40	Frequent conflicts at home?		
41	Sexual problems?		
42	Do you feel anxious or depressed much of the time?		
43	Have you seriously considered suicide?		
44	Difficulty in sleeping?		
45	History of hospitalization for an emotional problem?		

	<b>WOMEN ONLY:</b>		
47	Are menstrual periods normal?		
48	Date of last menstrual period?		
49	Any Vaginal discharge?		
50	Pregnancies _____ Deliveries _____		
51	Bleeding between periods or after menopause?		
52	Approximate date of last PAP smear?		

<b>Have you ever had?</b>			
	Asthma		
	Diabetes		
	Heart Murmur		
	Heart Attack		
	Hepatitis or Liver Disease		
	Kidney Stones		
	Phlebitis		
	Pneumonia		
	Polio		
	Rheumatic Fever		
	Stroke		
	Thyroid Trouble		
	Tuberculosis		
	Ulcer		

Other serious illnesses not mentioned above. Please list below:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Patient \_\_\_\_\_

Reviewed by/Date \_\_\_\_\_