Today's Date: _____

MEDICAL HISTORY QUESTIONAIRE

(**Please** print)

Patient Name: _____ **Marital Status**: M/ W / S / D

Patient Date of Birth: _____ **Social Security Number: _____**

Children	**Date of birth**

Chief Complaint(s)/ Reason(s) for appointment:

_____

_____

_____

Allergies (drug or other):_____

_____

_____

List all Hospitalizations, Surgeries or Major Illnesses	Year and Reason

Medications(please include name dosage , include over the counter medications and supplements):_____

_____

_____

_____

_____

_____

_____

Have you ever had any of the following (circle yes or no, or leave blank if uncertain)?

AIDS OR HIV	Yes No	Anemia	Yes No	Arthritis	Yes No
Asthma	Yes No	Back Trouble	Yes No	Bladder Infection	Yes No
Bleeding Tendency	Yes No	Bronchitis	Yes No	Cancer	Yes No
Chickenpox	Yes No	Diabetes	Yes No	Diphtheria	Yes No
Epilepsy	Yes No	Glaucoma	Yes No	Heart Disease	Yes No
Hemorrhoids	Yes No	Hepatitis	Yes No	Hernia	Yes No
High Blood pressure	Yes No	Low Blood Pressure	Yes No	Hives	Yes No
Infectious		Kidney Disease	Yes No	Eczema	Yes No
Mononucleosis	Yes No	Mitral Valve Prolapse	Yes No	Measles	Yes No
Migraines	Yes No	Polio	Yes No	Mumps	Yes No
Pneumonia	Yes No	Small Pox	Yes No	Rheumatic Fever	Yes No
Scarlet Fever	Yes No	Transfusions	Yes No	Stroke	Yes No
Thyroid Disease	Yes No	Whooping Cough	Yes No	Ulcer	Yes No
Venereal Disease	Yes No			Blurred Vision	Yes No

Any other diseases, please specify here:

_____

_____

Review of Systems/ Past Medical History (circle all that apply)

GENERAL: Fever or chills, Night sweats, weight loss, weight gain, fatigue, cold or heat intolerance, Diabetes or thyroid problems

HEENT: EYES: Blurred vision, double vision, pain itching, watering
EARS/NOSE/THROAT: Ringing in ears, decrease hearing, ear pain or drainage, runny nose, Congestion, sneezing, sore throat swallowing difficulty

GASTRINTESTINAL: abdominal pain, bloating, belching, gas, heartburn, constipation, diarrhea, bloody Or tarry stool, change in stool size or color, consistency, or frequency, consistency Of stool (liquid/soft/hard)
Frequency (daily/ every other day/ bi weekly/ weekly) #stools per day_____

CARDIOVASCULAR: Chest pain (resting or with exertion), palpitations (fast or funny heart beats), Swelling, swollen ankles, leg pain when walking, fainting or blacking out, high Blood pressure

RESPIRATORY: cough (day or night), Shortness of Breath (rest or with exertion), sputum, and history of asthma/ Wheezing, bronchitis, pneumonia

GENITOURINARY: Urination (frequency of urination/ painful urination / bloody urine), History of kidney stones, sexually transmitted diseases, urinary tract infections

MUSCULOSKELETAL: pain or swelling in muscles or joints, weakness, Arthritis, osteoporosis, bone Fracture/ joint injury, gout

HEM/ LYMPH: Easy bleeding, or bruising, lumps or bumps in neck, armpits, groin, breasts, or Testicles

NEUROLGICAL: Numbness and tingling, fainting, blackouts, abnormal jerking, repetitious Movements, history of seizures, tremors, tics

SKIN: Acne, dry flaky, peeling, rash, redness, itching, recent change in moles/ lesions/ or Birthmarks.

Describe color/ location size: _____

PSYCHIATRIC: anxiety, crying episodes, depression, moodiness, paranoia, phobias

Please list problems not covered elsewhere:

_____

FAMILY HISTORY

	FATHER	MOTHER	BROTHER		SISTER		GRANDPARENTS			
			1	2	1	2	Father's Father	Father's Mother	Mother's Father	Mother's Mother
Age at death										
Health: G for Good, B for Bad										
Cancer										
TB										
Diabetes										
Heart Disease										
Stroke										
Epilepsy										
Nervous disorder										
Asthma, hives, hay fever										
Alcohol/ drug addiction										

Comments:_____
_____
_____

SOCIAL HISTORY:

Tobacco Use Yes No Packs per day_____ for_____ years
Alcohol Use Yes No Drinks per week _____
Caffeine Yes No Cups per day _____
Sexually Active Yes No Number of Individuals you have been sexually With _____.

Circle any high risk sexual contacts: Prostitutes / IV drug users / same sex
Method of Birth control (specify): _____
Uses seat belt Yes No
Religious/Church Affiliation _____

PREVENTION: Please write the date of the last time you had

Date:	**Date:**	**Date:**
Flu vaccine	Colonoscopy	Vaccine
Hepatitis Vaccine	Cholesterol Test	Rectal Exam
Pneumonia Shot	Tetanus Shot	Eye Exam
Blood stool test	TB test	PSA
Chickenpox/ Varicella vaccine	Results of TB Test Positive Negative	

For Women Only:

Age at onset of menstrual period: _____ and/ or age at menopause_____
1st day of last menstrual period __/___/___ Use of hormone replacement? Yes / No
Periods regular: Yes/ No Days of flow _____
Use of Birth Control: Yes/No, Specify type used _____
Number of pregnancies_____ Live births _____ Abortions _____ Miscarriages_____
Number of individuals you have been sexually active with_____
Do you perform monthly self-breast exams? Yes/ No

Please indicate date of:

Last breast exam __/__/__ Result _____
Mammogram __/__/__ Result _____
Pap __/__/__ Result _____

__ Vaginal discharge: _____ __ pain w/cycles __Lumpy Breasts
__ Pain with intercourse __ spotting __ hx of sexually transmitted disease
__ hot flashes __ PMS __ hx of abnormal pap
__ Painful breasts __ Rash __ dribbling/ incontinence of urine
__ decreased sex drive __ Mood Swings __ Nipple discharge

FOR CHILDREN UNDER 6, to be completed by the parent:

Birth History: __ premature __ Vaginal Birth __ C-section Delivery

Mothers age at birth: _____ Fathers age at birth _____

Medications during pregnancy_____

Prenatal problems_____

Birth weight _____ Birth length _____

Newborn problems _____

FOR MEN ONLY (check all that apply)

	Difficulty obtaining erection		Penile discharge/ bleeding
	Decreased sexual interest		Premature ejaculation
	Bladder or prostate infections		Painful ejaculation
	Penile/testicular pain/deformity		Bloody ejaculation
	Groin swelling or lumps		Performs monthly testicular exam Y N

Comments:

_____

_____

_____