



**Medical History Questionnaire (please print)**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Reason for visit \_\_\_\_\_

Medications

Please list all the medications you are currently taking, including strength and number of times per day taken.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medical History

Please mark any of the diagnoses that apply to you, please include the year you were diagnosed.

	<u>Year</u>		<u>Year</u>
<input type="checkbox"/> Acid Reflux	_____	<input type="checkbox"/> Emphysema	_____
<input type="checkbox"/> Allergic Rhinitis	_____	<input type="checkbox"/> Gout	_____
<input type="checkbox"/> Anxiety	_____	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> High Cholesterol	_____
<input type="checkbox"/> Atrial Fibrillation	_____	<input type="checkbox"/> Irritable Bowel Syndrome	_____
<input type="checkbox"/> Attention Deficit	_____	<input type="checkbox"/> Migraine	_____
<input type="checkbox"/> Congestive Heart Failure	_____	<input type="checkbox"/> Osteoarthritis	_____
<input type="checkbox"/> Coronary Artery Disease	_____	<input type="checkbox"/> Seizure Disorder	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Thyroid Disease	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Tobacco Use	_____
Other _____			



Drug Allergies

If you are allergic to any medications please write the name of the medication and the type of reaction you have to the medication.

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Surgical History

Please mark any of the surgeries that apply to you and give the year it was done.

	<u>Year</u>		<u>Year</u>
<input type="checkbox"/> Appendix	_____	<input type="checkbox"/> Mastectomy	_____
<input type="checkbox"/> Artery Bypass	_____	<input type="checkbox"/> Organ Transplant	_____
<input type="checkbox"/> Balloon Angioplasty	_____	<input type="checkbox"/> PE Tubes	_____
<input type="checkbox"/> Balloon Angio/stent	_____	<input type="checkbox"/> Prostate Surgery	_____
<input type="checkbox"/> Colon Surgery	_____	<input type="checkbox"/> Splenectomy	_____
<input type="checkbox"/> Disc Surgery	_____	<input type="checkbox"/> Tonsillectomy	_____
<input type="checkbox"/> Gallbladder	_____	<input type="checkbox"/> Tubal Ligation	_____
<input type="checkbox"/> Heart Bypass	_____	<input type="checkbox"/> Valve Replacement	_____
<input type="checkbox"/> Hysterectomy	_____	<input type="checkbox"/> Vasectomy	_____
<input type="checkbox"/> Knee Surgery	_____		
<input type="checkbox"/> Other _____			

Family History

Please mark the disease and circle the family member who has had this disease.

(F= Father, M= Mother, B= Brother, S= Sister, GP= Grandparent)

<input type="checkbox"/> Breast Cancer	M S GP	<input type="checkbox"/> Heart Disease	F M B/S GP
<input type="checkbox"/> Colon Cancer	F M B/S GP	<input type="checkbox"/> Melanoma	F M B/S GP
<input type="checkbox"/> Diabetes	F M B/S GP	<input type="checkbox"/> Prostate Cancer	F B GP

Adopted



### Social History

We would like to get to know you better, please fill out the information below.

Marital Status \_\_\_\_\_ Occupation \_\_\_\_\_

Name of Spouse \_\_\_\_\_

Names of Children \_\_\_\_\_

Exercise per week \_\_\_\_\_

Smoking (packs/day) \_\_\_\_\_ Drinks per day \_\_\_\_\_

### Health History

Do you have a living will? Y/N \_\_\_\_\_ Date last reviewed \_\_\_\_\_

When was your last complete physical? \_\_\_\_\_

When was your last Tetanus booster? \_\_\_\_\_

Have you received a pneumonia vaccine? Y/N \_\_\_\_\_ Date of vaccine \_\_\_\_\_

### Men and Women Over Age 50

When did you last have:-

A stool specimen tested for blood/cancer? \_\_\_\_\_

A colonoscopy or sigmoidoscopy to check for colon cancer? \_\_\_\_\_

An exercise stress test? \_\_\_\_\_ An EKG? \_\_\_\_\_

### FOR MEN OVER 50

When was your last PSA blood test? \_\_\_\_\_

### FOR WOMEN ONLY

When was your last mammogram? \_\_\_\_\_ At which facility \_\_\_\_\_

When was your last pap smear? \_\_\_\_\_ Performed by: \_\_\_\_\_

When was your last bone density scan? \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_