



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.

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 _____