MEDICAL HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Date Questionnaire Completed:				
Name *(Last, First, M.I.)*:		☐ M ☐ F	**DOB:**	
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Primary medical provider:		**Date of last physical exam:**		
Other physicians involved in your care:				

PERSONAL MEDICAL HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio			
Immunizations and dates:	☐ Tetanus		☐ Pneumonia	
	☐ Varicella		☐ Smallpox	
	☐ Hep B		☐ Chickenpox	
	☐ Influenza		☐ MMR *Measles, Mumps, Rubella*	
	☐ Hep A			

List any medical problems that other doctors have diagnosed and approximate date of diagnosis

Surgeries

Year	Operation	Year	Operation

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No
If yes, list date(s):		

Please turn to next page

List your prescribed drugs and inhalers		
Drug Name	Strength	Frequency Taken
List your vitamins, herbal medications, and over-the-counter medications		
Herbal medication / Vitamin / OTC	Reason for taking	Strength and frequency
Allergies to medications		
Name the Drug	Reaction you had and approximate date when it occurred	

FAMILY HEALTH HISTORY						
☐ Unknown ☐ Adopted						
	Heart disease	Hypertension	Stroke	Diabetes	Cancer (type)	Other
Mother	☐	☐	☐	☐	☐	
Father	☐	☐	☐	☐	☐	
Siblings	☐	☐	☐	☐	☐	
Children	☐	☐	☐	☐	☐	
Grandparents	☐	☐	☐	☐	☐	
Other						

OTHER MEDICAL HISTORY

HEALTH HABITS							
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.							
Exercise	☐ Sedentary (No exercise)						
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)						
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)						
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)						
Diet	Are you dieting?					☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?					☐ Yes	☐ No
	# of meals you eat in an average day?						
	Rank salt intake	☐ High	☐ Medium	☐ Low			
	Rank fat intake	☐ High	☐ Medium	☐ Low			
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola			
	# of cups/cans per day?						
Alcohol	Do you drink alcohol now?					☐ Yes	☐ No
	How many drinks per week?						
	Are you concerned about the amount you drink?					☐ Yes	☐ No
	Have you considered stopping?					☐ Yes	☐ No
	Have you ever experienced blackouts?					☐ Yes	☐ No
	Are you prone to "binge" drinking?					☐ Yes	☐ No
	Do you drive after drinking?					☐ Yes	☐ No
	Did you drink significantly in the past? ☐ Yes		If yes, the year you quit or cut down:				
Tobacco	Did you ever use tobacco?					☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	Year you started using tobacco:			If you quit, the year you did:			
Drugs	Do you use recreational or street drugs?					☐ Yes	☐ No
	What drugs have you used?						
	If you no longer use recreational drugs, when did you quit?						
	Do you currently use marijuana?					☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?					☐ Yes	☐ No
Sex	Are you sexually active?					☐ Yes	☐ No
	If yes, are you trying for a pregnancy?					☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:						
	Any discomfort with intercourse?					☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?					☐ Yes	☐ No
Personal Safety	Do you live alone?					☐ Yes	☐ No
	Do you have frequent falls?					☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will?					☐ Yes	☐ No
	Would you like information on the preparation of these?					☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?					☐ Yes	☐ No

CHECK THE PROBLEMS YOU HAVE HAD OR NOW HAVING					
☐	Fever/Chills	☐	Feel "ill"	☐	Weight loss or gain
☐	Nausea/Vomiting	☐	Feel "tired"	☐	Eye pain
☐	Double vision	☐	Dry eyes	☐	Itchy eyes
☐	Red eyes	☐	Discharge from eyes	☐	Headaches
☐	Poor hearing	☐	Frequent nosebleeds	☐	Sore throat
☐	Ear pain	☐	Runny nose	☐	Hoarseness
☐	Chest pain	☐	Short of breath lying flat on your back	☐	Legs hurt when walking
☐	Palpitations	☐	Awake at night short of breath	☐	Swelling of legs
☐	Shortness of breath	☐	Cough	☐	Pain with breathing
☐	Wheezing	☐	Short of breath with exertion	☐	Heartburn
☐	Abdominal pain	☐	Blood in stools	☐	Black tarry stools
☐	Diarrhea	☐	Constipation	☐	Pain with urination
☐	Frequently urinating	☐	Blood in urine	☐	Urinate frequently at night
☐	Joint pain	☐	Muscle pain	☐	Joint stiffness
☐	Leg cramps	☐	Back pain	☐	Itching
☐	Rash	☐	Concerning skin lesions	☐	Poor memory
☐	Seizures	☐	Passing out	☐	Dizziness/vertigo
☐	Localized weakness	☐	Difficulty with walking	☐	Drooping eyelid(s)
☐	Generalized weakness	☐	Increased urination	☐	Increased thirst
☐	Easy bleeding	☐	Easy bruising	☐	Swollen glands

MENTAL HEALTH				
Is stress a major problem for you?	☐	Yes	☐	No
Do you feel depressed?	☐	Yes	☐	No
Do you panic when stressed?	☐	Yes	☐	No
Do you have problems with eating or your appetite?	☐	Yes	☐	No
Do you cry frequently?	☐	Yes	☐	No
Have you ever attempted suicide?	☐	Yes	☐	No
Have you ever seriously thought about hurting yourself?	☐	Yes	☐	No
Do you have trouble sleeping?	☐	Yes	☐	No
Have you ever been to a counselor?	☐	Yes	☐	No

WOMEN ONLY				
Age at onset of menstruation:				
Date of last menstruation:				
Period every days				
Heavy periods, irregularity, spotting, pain, or discharge?	☐	Yes	☐	No
Number of pregnancies Number of live births				
Are you pregnant or breastfeeding?	☐	Yes	☐	No
Any urinary tract, bladder, or kidney infections within the last year?	☐	Yes	☐	No
Any problems with control of urination?	☐	Yes	☐	No
Any hot flashes or sweating at night?	☐	Yes	☐	No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐	Yes	☐	No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐	Yes	☐	No
Date of last pap and rectal exam?				

MEN ONLY				
Do you usually get up to urinate during the night?	☐	Yes	☐	No
If yes, # of times				
Do you feel burning discharge from penis?	☐	Yes	☐	No
Has the force of your urination decreased?	☐	Yes	☐	No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐	Yes	☐	No
Do you have any problems emptying your bladder completely?	☐	Yes	☐	No
Any difficulty with erection or ejaculation?	☐	Yes	☐	No
Any testicle pain or swelling?	☐	Yes	☐	No
Date of last prostate and rectal exam?				

Person Completing This Questionnaire: ☐ Self ☐ Other:
Signature of person completing this form:
Suggestions for improving this questionnaire: