Medical History

Questionnaire

Please complete this questionnaire. It will provide our care team with valuable information about your overall health. All answers in the questionnaire are confidential and part of your medical record.

Name (Last, First, M.I.):_____ ☐ M ☐ F
DOB:_____

Date:_____ Marital status: ☐ Single ☐ Partnered ☐ Married

☐ Separated ☐ Divorced ☐ Widowed

Number of children:_____ How many live with you?_____

Occupation is/was:_____

Previous or referring doctor_____

Date of last physical exam:_____

Personal History

Immunizations and Dates: ☐ Tetanus_____ ☐ Pneumonia_____

☐ Hepatitis A_____ ☐ Hepatitis B_____

☐ Covid-19_____ ☐ Influenza_____ ☐ MMR Shingles, Mumps, Rubella_____

☐ Meningococcal_____ ☐ None/unknown

Tests/Screenings and Dates: ☐ Eye Exam_____ ☐ Colonoscopy_____

☐ Bone Density Scan_____ ☐ Mammo _____ ☐ PAP/Pelvic _____

Surgeries/ Hospitalizations

_____

_____

_____

☐ I have had no surgeries/hospitalizations

Please list any other specialist you have seen or are currently seeing:

1._____ 2. _____

3. _____ 4. _____

5._____6._____

Please indicate if YOU have a history of the following: **Check all that apply**

☐ Alcohol Abuse ☐ Anemia ☐ Anesthetic Complication ☐ Anxiety Disorder

☐ Arthritis ☐ Asthma ☐ Autoimmune Problems ☐ Birth Defects

☐ Bladder Problems ☐ Bleeding Disease ☐ Blood Clots ☐ Blood Transfusion(s) ☐ Bowel Disease ☐ Breast Cancer ☐ Cervical Cancer ☐ Colon Cancer ☐ Depression ☐ Diabetes ☐ Growth/Development Disorder ☐ Hearing Impairment ☐ Heart Attack ☐ Heart Disease ☐ Heart Pain/Angina Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ High Blood Pressure ☐ High Cholesterol ☐ HIV ☐ Hives

☐ Kidney Disease ☐ Liver Cancer ☐ Liver Disease ☐ Lung Cancer

☐ Lung/Respiratory Disease ☐ Mental Illness ☐ Migraines ☐ Obesity

☐ Osteoporosis ☐ Prostate Cancer ☐ Rectal Cancer ☐ Reflux/GERD

☐ Seizures/Convulsions ☐ Seasonal Allergies ☐ Severe Allergy

☐ Sexually Transmitted Disease ☐ Skin Cancer ☐ Stroke/CVA of the Brain

☐ Suicide Attempt ☐ Thyroid Problems ☐ Ulcer ☐ Visual Impairment

☐ Other Disease, Cancer, or SignificantMedical Illness

☐ **NONE of the Above**

Family Medical History

Please indicate if YOUR FAMILY has a history of the following: (ONLY include parents, grandparents, siblings, and children) ☐ I am adopted and do not know biological family history

☐ Family History Unknown

☐ Alcohol Abuse ☐ Anemia ☐ Anesthetic Complication ☐ Arthritis ☐ Asthma

☐ Bladder Problems ☐ Bleeding Disease ☐ Breast Cancer ☐ Colon Cancer

☐ Depression ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure

☐ High Cholesterol ☐ Kidney Disease ☐ Leukemia ☐ Lung/Respiratory Disease

☐ Migraines ☐ Osteoporosis ☐ Other Cancer ☐ Rectal Cancer

☐ Seizures/Convulsions ☐ Severe Allergy ☐ Stroke/CVA of the Brain

☐ Thyroid Problems

☐ NONE of the Above

Allergies:

Name_____ Reaction You Had_____

Name_____Reaction You Had_____

Name_____ Reaction You Had_____

Name_____ Reaction You Had_____

☐ **I have no known drug allergies**

Social History

Exercise Do you exercise?.. ☐ Y ☐ N

If yes, how many minutes per week?_____

Diet Are you dieting? ☐ Y ☐ N

If yes, are you on a physician prescribed medical diet?.....☐ Y ☐ N

Alcohol Do you drink alcohol?.....☐ Y ☐ N

If yes, what kind?_____ How many drinks per week?_____

Tobacco Do you use tobacco?.....☐ Y ☐ N

☐ Cigarettes – pks./day_____ or pks./week _____ ☐ Chew - #/day_____

☐ Pipe - #/day_____ ☐ Cigars - #/day_____

☐ # of years_____ ☐ Previous tobacco user - year quit _____

Your healthcare provider needs to know:

Do you have Advanced Directives? (Advance Directives refer to a person's instructions about future medical care, in the event the person becomes unable to speak for himself/herself. A Living Will is an example of an Advance Directive.).....☐ Y ☐ N

If no, would you like additional details about Advanced Directives?.....

☐ Y ☐ N

Please circle any symptoms you are currently experiencing or symptoms you have frequently experienced in the past. **Circle all that apply:**

Abdominal Pain	Ear ache	Muscle pain
Anxiety	Easy bleeding or bruising	Nail discoloration/deforming
Back Pain	Emotional problems	Nosebleeds
Black, Tarry stool	Eyes itch	Numbess/tingling
Blood per Rectum	Eye pain	Pain with urination
Change in Mole	Eyesight problems	Palpations
Change in Personality	Fainting	Recent weight loss
Chest pain	Fast/slow heartbeat	Recent weight gain
Chills	Feeling poorly	Red eyes
Cold hands/feet	Feeling tired/fatigued	Ringing in ears
Confusion	Fever	Shortness of breathe
Constipation	Frequent falls	Shortness of breathe with activity
Convulsions/Seizures	Frequent urination at night	Sinus problems
Cough	Hairloss	Skin lesions
Coughing up Phlegm/Blood	Heartburn	Skin wound
Decreased Libido/ Sexual Desire	History of Heart Attack	Sleep disturbances
Deepening of voice	History of Heart Murmur	Sore throat
Depression	Hoarseness	Suicidal
Diarrhea	Itching	Swelling in legs
Difficulty breathing while laying down/ sleeping	Joint Stiffness	Swollen Glands

Difficulty walking	Joint Swelling	Urinary frequency
Discharge from eyes	LImb Pain	Urinary incontinence
Discharge from nose	Limb Weakness	Vision change
Dizziness	Loss of hearing	Vomitting
Dry eyes	Muscle/joint pain	Wheezing