MEDICAL HISTORY QUESTIONNAIRE

Name_____ ***Age***_____ ***Date***_____

Past Medical History

Cardiac
- □ Chest Pain
- □ High Blood Pressure
- □ High Cholesterol
- □ Heart Attack
- □ Congestive Heart Failure
- □ Heart Murmur
- □ OTHER_____

Respiratory
- □ Cough
- □ Asthma
- □ COPD
- □ OTHER_____

Digestive:
- □ Gastroesophageal Reflux
- □ Peptic Ulcer Disease
- □ Liver Disease
- □ Hemorrhoids
- □ Colitis
- □ OTHER_____

Urinary
- □ Prostate enlargement
- □ Kidney Stones
- □ Urinary Infections
- □ Kidney Failure
- □ OTHER_____

Endocrine:
- □ Diabetes
- □ Thyroid disease
- □ Osteoporosis
- □ Steroids
- □ OTHER_____

Hematologic:
- □ Anemia
- □ Bleeding Problems
- □ Transfusions
- □ Cancer – What kind?_____
- □ OTHER _____

Neurologic
- □ Headaches
- □ Stroke
- □ Seizures
- □ OTHER_____

Vision
- □ Glaucoma
- □ Macular Degeneration
- □ Cataracts
- □ OTHER_____

Psychiatric
- □ Depression
- □ Anxiety
- □ Eating Disorder
- □ OTHER_____

Muscular
- □ Back Pain
- □ Arthritis
- □ OTHER _____

Allergies (please list)

Medications (please list with doses)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Surgical History (please list with dates)

_____
_____
_____
_____

Social History

Do you smoke tobacco? Yes No
If so, how much?_____
Do you drink alcohol? Yes No
If so, how much?_____
What is your occupation?_____
Who do you live with?_____

Family History

Mother (circle one) Living Deceased Age_____
Medical Problems_____

Father (circle one) Living Deceased Age_____
Medical Problems_____

Any Relatives with the following:
Colon Cancer Y N Who?_____
Breast Cancer Y N Who?_____
Prostate Cancer Y N Who?_____
Heart Problems Y N Who?_____

Preventative Medical History

When was your last…..?
Tetanus Shot_____
Flu Shot _____
Pnemovax _____
Colonoscopy_____
Bone Density _____

Menstrual Period_____
PAP smear _____
Mammogram_____