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MEDICAL HISTORY

PERSONAL INFORMATION

First Name_____ MI _____ Last Name _____ ☐M ☐ F DOB ___/____/_____

Today's date _____ Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Number of children _____ How many live with you? _____ Occupation Is/Was: _____

Previous or referring doctor_____ Date of last physical: _____

PERSONAL HEALTH HISTORY

Childhood Illness ☐ Measles ☐ Mumps ☐Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ None

Immunizations and Dates: ☐Tetanus_____ ☐ Pneumonia_____ ☐Hepatitis A _____
☐Hepatitis B_____ ☐Chickenpox _____ ☐Influenza _____ ☐Meningococcal _____

☐MMR (*Measles, Mumps, Rubella*)_____ ☐None

Test Screenings and Dates: ☐ Eye Exam _____ ☐ Colonoscopy _____ ☐ Dexa Scan _____

Surgeries

Year _____ Reason _____ Hospital _____

Year _____ Reason _____ Hospital _____

Year _____ Reason _____ Hospital _____

Year _____ Reason _____ Hospital _____

☐ I have had no surgeries

Other Hospitalizations

Year _____ Reason _____ Hospital _____

Year _____ Reason _____ Hospital _____

Year _____ Reason _____ Hospital _____

Year _____ Reason _____ Hospital _____

☐ I have never been hospitalized

Have you ever had a blood transfusion? ☐ Yes ☐No

Please list other physicians you have seen in the last 12 months, and for what reason.

_____

_____

_____

_____

_____

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YOUR MEDICAL HISTORY

Please indicate if **YOU** have a history of the following

- ☐ 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
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Hives
- ☐ Kidney Disease
- ☐ Lung Cancer
- ☐ Lung/Respiratory Disease
- ☐ Mental Illness
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Prostrate Cencer
- ☐ Rectal Cancer
- ☐ Reflux/GERD
- ☐ Seizures/Convulsions
- ☐ Severe Allergy
- ☐ Sexually Transmitted Disease
- ☐ Skin Cancer
- ☐ Stroke/CVA of the Brain
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Ulcer
- ☐ Visual Impairment
- ☐ Other Disease or Significant Illness
- ☐ None of the Above

List other past medical problems _____
_____

List your prescribed drugs and over the counter drugs such as vitamins and inhalers

Drug _____ Dose/Frequency _____ Drug _____ Dose/Frequency _____

Drug _____ Dose/Frequency _____ Drug _____ Dose/Frequency _____

Drug _____ Dose/Frequency _____ Drug _____ Dose/Frequency _____

Drug _____ Dose/Frequency _____ Drug _____ Dose/Frequency _____

☐ List additional drugs on back of questionnaire

☐ I take no medications, vitamins, herbals, or any other over-the-counter preparations

Allergies

Name _____ Reaction you had _____

Name _____ Reaction you had _____

☐ I have no known **drug** allergies

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FAMILY MEDICAL HISTORY

Please indicate if **YOUR FAMILY** has a history of the following: *(**Only** include parents, grandparents, siblings, children)*

☐I am adopted and do not know biological family history

☐	Family History Unknown	☐	Colon Cancer	☐	Migraines
☐	Alcohol Abuse	☐	Depresssion	☐	Osteoporosis
☐	Anemia	☐	Diabetes	☐	Other Cancer
☐	Anesthetic Complication	☐	Heart Disease	☐	Rectal Cancer
☐	Arthritis	☐	High Blood Pressure	☐	Seizures/Convulsions
☐	Asthma	☐	High Cholesterol	☐	Severe Allergy
☐	Bladder Problems	☐	Kidney Disease	☐	Stroke/CVA of the Brain
☐	Bleeding Disease	☐	Leukemia	☐	Thyroid Problems
☐	Breast Cancer	☐	Lung/Respiratory Disease	☐	None of the above

☐ Mother, Grandmother, or Sister developed heart disease before the age of 65
☐ Father, Grandfather, or Brother developed heart disease before the age of 55

SOCIAL HISTORY

All questions contained in this questionnaire are optional and will be kept strictly confidential

Exercise
Do you exercise? ☐ Yes ☐No
If yes, how many minutes per week? ☐ Yes ☐No

Diet
Are you dieting? ☐ Yes ☐No If yes, are you on a physician prescribed medical diet? ☐ Yes ☐No
Number of meals you eat in an average day? _____
Rank salt intake ☐ High ☐Med ☐ Low
Rank fat intake ☐ High ☐Med ☐ Low

Caffeine
☐None ☐Coffee ☐Tea ☐Cola # of cups/cans per day? _____

Alcohol
Do you drink alcohol? ☐ Yes ☐No
If yes, what kind? _____ 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

Tobacco
Do you use tobacco? ☐ Yes ☐No
# of years _____ # of pks/day _____ or # of pks/week _____
Are you a previous tobacco user – what year did you quit? _____

Drugs
Do you currently use recreational or street drugs? ☐ Yes ☐No
Have you ever given yourself street drugs with a needle? ☐ Yes ☐No

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Sex

Are you sexually active?	☐ Yes	☐No
If yes, are you and your partner trying for a pregnancy?	☐ Yes	☐No
If not trying for a pregnancy, list contraceptive or barrier method use?	☐ Yes	☐No
Any discomfort with intercourse?	☐ Yes	☐No

Illness related to 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 risk of this illness? ☐ Yes ☐No

PERSONAL SAFETY

Do you live alone?	☐ Yes	☐No
Do you have frequent falls?	☐ Yes	☐No
Do you have vision or hearing loss?	☐ 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

OTHER INFORMATION

Your healthcare provider needs to know:

Do you have Advanced Directives? ☐ Yes ☐No

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

If no, would you like additional details about Advanced Directives? ☐ Yes ☐No

Do you have any religious or cultural beliefs that may impact your healthcare? ☐ Yes ☐No

If yes, please describe _____

_____

Patient's Signature: _____ Date: _____/____/_____

Reviewed By: _____ Date: _____/____/_____