

Name _____

Date _____

Medical History Questionnaire

Please complete this medical history form to the best of your ability. If you need assistance, ask the assistant that brings you to the exam room for help. Please print clearly.

Allergies?	Medication	Reaction	Medication	Reaction
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If more space is needed, please continue list on back of page.

Medications

Name	Dose	Frequency	Name	Dose	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

If more space is needed, please continue list on back of page.

Herbal Supplements? Please list any herbal supplements that you take.

Medical History and Review of Systems

General symptoms

- Weight gain _____ lbs
- Weight loss _____ lbs
- Fevers
- Chills
- Night sweats

Ear, Nose Throat

- Hearing loss
- Visual problems
- Headache

Cardiovascular System

- High blood pressure
- Heart attack
- Chest pain
- Arrhythmia
- Circulation problems
- High cholesterol
- Heart failure
- Heart murmur
- Other _____

Pulmonary Disease

- Shortness of breath
- Asthma
- Emphysema
- Other _____

Gastrointestinal Disease

- Diarrhea
- Constipation
- Hepatitis **A B C** (circle one)
- Ulcers, acid reflux, GERD

Urinary Disorders

- Incontinence Stress?
- Prostate
- Other _____

Skin

- Psoriasis
- Eczema

Endocrine

- Diabetes
- Thyroid Disease

Neuro/Psych

- Stroke
- Seizure
- Depression
- Anxiety
- Other _____

Musculoskeletal

- Arthritis/Rheumatism
- Gout
- Osteoporosis
- Fractures _____
- _____
- _____

Cancer

- _____
- _____
- _____

Name _____

Date _____

Past Surgical History

Procedure	Date	Procedure	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If more space is needed, please continue list on back of page.

Family History

	Father	Mother	Siblings
Deceased? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart failure _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____			

Surgical Risks

- Latex Allergy ? Yes No
- Blood Transfusion? Yes No
- Reaction ? Yes No
- Reaction to Anesthesia ?
- Personal Yes No
- Family Yes No
- History of Blood Clots ?
- Legs Yes No
- Lungs Yes No

Social History

Tobacco: Cigarettes _____ packs/day _____ yrs Alcohol: Type _____ amnt/freq _____

Recreational drugs Yes No Type? _____

Living Situation (Circle answer) Home Other _____ Family Alone

Occupation _____ Employer _____

Working? Yes No Last Date Worked _____

Education: Highest level of education completed _____

Sports/Hobbies _____

By signing this form, I certify the information provided is accurate and correct to the best of my knowledge.

Signature _____ Date _____

