Patient Medical History Questionnaire

NAME:_____Date of Birth _____Age_____Today's Date_____

Occupation:_____Family Doctor_____

Chief Complaint (primary reason for this visit)_____

Medication (name, strength, frequency)

1) _____2)_____3)_____

4) _____5) _____6) _____

Do you take aspirin? _____ How often? _____

Allergies to Drugs? (name and type of reaction) 1) _____2)_____
3) _____ Iodine? _____ Adhesive tape? _____ Local Anesthetic?_____

Previous Operations

Type of Operation	Date	Diagnosis	Surgeon/Hospital
1)			
2)			
3)			
4)			

Illnesses. Circle if you have had any of the following;: Thyroid Disorder Tuberculosis Emphysema Diabetes

Heart Disease High blood Pressure Hepatitis AIDs Jaundice Rheumatic Fever Bleeding Disorders

Ulcers Colitis Cancer Diverticulitis Seizure Disorder/Epilepsy Phlebitis Pneumonia

Other Illnesses_____

Previous Hospitalizations not listed above – Include reason and dates._____

Habits Do you currently smoke? _____ In the past? _____ How much? _____ How long?_____

Do you drink alcohol? _____ In the past?_____ How much?_____How long?_____

Other drug Use? _____ How often?_____

Family History	Living/Age	Deceased/Age of Death	Cause of Death/Significant Illnesses
Father			
Mother			
Brother			
Sister			

Has any blood relative had (or died from) any of the following? Circle and indicate relationship.

Cancer (type if known)_____ Tuberculosis_____AIDS_____Hepatitis_____

Heart Disease_____ Cirrhosis_____ Ulcer Disease_____ Bleeding Disorder_____

Other: _____

Circle all that apply:

GENERAL: Weight gain or Loss?_____Lbs. SKIN: Rash Night Sweats Itching

HEAD: Persistent headaches Injury Dizziness NEURO: Seizures/Convulsions Numbness

EYES: Glasses Loss of vision Pain Injury

EARS: Pain Discharge Loss of hearing Injury

NOSE: Frequent nosebleeds Sinus trouble Injury

MOUTH & THROAT: Bleeding gums Frequent sore throat Tooth decay

NECK: Lumps Swollen glands Goiter Injury

LUNGS/CHEST: Bloody sputum Pneumonia Asthma Emphysema Blood clots to lungs
Chronic cough Injury Shortness of breath Date of last chest X-ray _____

BREASTS: Lumps Tenderness Nipple discharge Injury

HEART: Heart attack Chest or arm pain Shortness of breath Swelling of feet or legs
High cholesterol Date of last electrocardiogram? _____

INTESTINAL TRACT: Loss of appetite/Nausea Vomiting/Vomiting of blood/ Difficulty swallowing
Bleeding from rectum Cramps Diarrhea Constipation Change in bowel habits
Hemorrhoids Ulcers Gallbladder disease Heartburn Tumor Colitis
Are there any foods you cannot eat (please list)? _____

URINARY TRACT: Infection Bleeding Burning/Pain on urination Night urination Stones
Difficulty starting stream loss of urine with coughing Tumor

FEMALE SYSTEM: Pain with periods bleeding between periods Discharge Age period began
Age period ended____ Length between periods__ Days of flow___Date of last period_____
Of Pregnancies_____ Number of miscarriages/abortions____Date of last PAP smear____

MALE SYSTEM: Discharge Pain Mumps Swelling

EXTREMITIES: Varicose veins Swelling Phlebitis or blood clots in legs Injury