PATIENT MEDICAL HISTORY QUESTIONAIRE

Date Completed: _____

Patient Name: _____ Date of Birth: _____

PRESENT ILLNESS (What you are being seen for) _____

PAST MEDICAL HISTORY:

SURGERY: Please list the year and the procedure and the doctor who performed the operation.

1.
2.
3.
4.

PAST SERIOUS ILLNESS (such as pneumonia, rheumatic fever, malaria, hepatitis, etc.)

1.
2.

CHILDHOOD DISEASE-Have you had the usual childhood diseases-measles, mumps, chicken pox?

Yes _____ No _____ Any complications? _____

FAMILY HISTORY:

Are your parents living? (If deceased, please give age and cause of death)

Mother _____ Father _____

Number of brothers _____ Number of sisters _____

Please list any medical problems your family members may have, such as cancer, heart trouble, diabetes, tuberculosis, epilepsy:

_____

Number of children (please give age and gender) _____

PATIENT HISTORY

AGE _____ HEIGHT _____ WEIGHT _____

ALLERGIES TO MEDICATIONS _____

Skin-any problems or conditions? _____

Headaches-migraines, sinus, tension? _____

Head injury in the past (concussion etc.) _____

EYES-any eye problems? _____

Do you wear glasses? _____ Contacts? _____

TEETH-do you have caps, crowns, partial or dentures? _____

EARS-do you have any ear trouble or hearing loss? _____

NOSE-do you have any nasal trouble-sinus, colds, nosebleeds? _____

THROAT-do you have hoarseness or frequent sore throats or laryngitis? _____

CHEST-do you have chest pain? _____ Why? _____

Do you ever spit or cough up blood? _____

Do you smoke? _____ How much and for how long in years? _____

Do you have shortness of breath? _____ When (exercise, stairs, other) _____

MUSCLE / BONES - do you have joint pain, swelling in joints? _____

Do you have arthritis? _____ Where? _____

Do you have back trouble of any kind? _____

Do you have varicose veins? _____ Which leg? _____

HEART- do you have heart trouble of any kind? _____

Do you take any medication for your heart? _____

Do you have high blood pressure? _____ Medication: _____

STOMACH AND DIGESTIVE SYSTEM - Is your appetite good, fair or poor? _____

Is your bowel action normal? _____ constipated? _____ diarrhea? _____

Do you have hemorrhoids? _____ Bleeding from the rectum? _____

Have you ever had a hernia (rupture) in the abdomen? _____

KIDNEYS - have you ever had kidney or bladder trouble? _____

MENTAL / EMOTIONAL - have you ever had mental or emotional problems? _____

Do you ever take tranquilizers or sleeping pills? _____

<u>ROUTINE MEDICATIONS</u> – Please list all medications you take on a daily basis:

1. 4.
2. 5.
3. 6.

FEMALE ONLY:

Have you had a hysterectomy? _____

Last monthly period (if still menstruating) _____

Is cycle regular or irregular _____ how long does it usually last _____

Number of pregnancies _____ Number of children born to you _____ miscarriages _____

When was your last pelvic exam and PAP smear? _____ Doctor's name _____

Are you now, or could you be, pregnant? Yes _____ No _____

Do you take any hormones? _____ Name: _____

Do you take birth control pills? _____ Name: _____