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MEDICAL HISTORY QUESTIONNAIRE

Today's Date: ____________________________

Last Name: ___________________________ First Name: ____________________________ DOB: _________________

Date of Last Physical Exam: _______________________ Provider Name: ______________________________________

Provider Address: ____ City, State, Zip: _____________________________

PERSONAL HABITS:

- Have you ever smoked? Yes ____ No ____ If Yes, do you still smoke? _____ Number of years? _______
  Month/Year You Quit? ____/_____ How much do you/did you smoke per day? __________________
- Have you ever used chewing tobacco? Yes ____ No ____ How often? _____________
  Month/Year You Quit? ____/_____
- Do you regularly drink alcohol? Yes ____ No ____ If yes, how often? ____________________________
- Have you ever used any of the following? Marijuana _____ LSD _____ Heroin _____ Cocaine _____
  Other? ____

PAST HISTORY: Have YOU had any of the following illnesses/conditions?

	YES	NO
Amputation	☐	☐
Anemia	☐	☐
Anxiety	☐	☐
Alcohol Abuse/Overuse	☐	☐
Allergies (other than medications)	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Bleeding Disorder	☐	☐
Cancer (location: ____________)	☐	☐
Cardiac Arrhythmias	☐	☐
Cerebral Palsy	☐	☐
Chicken Pox	☐	☐
Colitis	☐	☐
CVA/TIA	☐	☐
Depression	☐	☐
Diabetes	☐	☐
Emphysema/COPD	☐	☐
Falls	☐	☐
Gallbladder Disease	☐	☐
Gout	☐	☐
HIV/AIDS	☐	☐
Heart Attack/MI	☐	☐

	YES	NO
Heart Disease	☐	☐
Hepatitis (Type: ___________)	☐	☐
High Blood Pressure	☐	☐
Irritable Bowel Syndrome	☐	☐
Jaundice	☐	☐
Kidney Disease	☐	☐
Measles/Mumps	☐	☐
Migraine Headaches	☐	☐
Multiple Sclerosis (MS)	☐	☐
Nervous Breakdown	☐	☐
Ostomies (_______________)	☐	☐
Pacemaker	☐	☐
Paralysis	☐	☐
Parkinson's Disease	☐	☐
Rheumatic Fever	☐	☐
Seizures	☐	☐
STI's/STD's	☐	☐
Sickle Cell Anemia	☐	☐
Sleep Disorder	☐	☐
Stomach Ulcers	☐	☐
Thyroid Disease	☐	☐
Vascular Disease	☐	☐

Other: ___________________________________

Last Name: ____________________________ First Name: _____________________________ DOB: _________________

PREVENTIVE SERVICE HISTORY:

Preventive Service	Date Received	Findings and Recommendations
Bone Mass Measurement (DEXA)	_____________________	____
Cardiovascular Disease Screening	_____________________	____
Cholesterol	_____________________	____
LDL/HDL/Triglycerides	_____________________	Hyperlipidemia? ___________________________
EKG	_____________________	EKG Result: _______________________________
Endoscopy	_____________________	____
Colonoscopy	_____________________	____
Colorectal Cancer Screening	_____________________	____
Flexible Sigmoidoscopy	_____________________	____
Barium Enema	_____________________	____
Fecal Occult Blood Test	_____________________	____
Diabetes Screening	_____________________	____
HgA1c	_____________________	____
Foot Exam	_____________________	____
Eye Exam	_____________________	Cataracts? _______________________________
Vision Test/Screening	_____________________	____
Glaucoma Screening	_____________________	Glaucoma Result: _________________________
Hearing Test/Screening	_____________________	____
Full Body Skin Cancer Screening	_____________________	____
PAP and/or Pelvic Exam	_____________________	____
Breast Exam	_____________________	____
Mammogram Screening	_____________________	____
Monthly Self Breast Exams?	_____________________	Anything detected? _______________________
Prostate Exam (Digital Rectal/DRE)	_____________________	____
Prostate Specific Antigen Test (PSA)	_____________________	____

Last Name: ____________________________ First Name: _____________________________ DOB: _________________

NUTRITIONAL HISTORY: Height: _____ft _____ in Weight: _________ lbs

Weight changes in past 6 months? ___________________________ Current Diet Plan: _____________________________

Current Activity Level: ______________________________________ How Often? _______________________________

Physical Limitations: ____

IMMUNIZATIONS:

☐ Flu	Last Rec'd? ___________	☐ Pneumonia	Last Rec'd? ___________
☐ Tetanus	Last Rec'd? ___________	☐ Chicken Pox	Last Rec'd? ___________
☐ Hepatitis A	Last Rec'd? ___________	☐ Hepatitis B	Last Rec'd? ___________
☐ Shingles	Last Rec'd? ___________	☐ Polio	Last Rec'd? ___________
☐ Typhoid	Last Rec'd? ___________	☐ Smallpox	Last Rec'd? ___________

EXAMS:

Date of Last Foot Exam: _______________ Provider: __________________________ Result: _______________________

Date of Last Eye Exam: ________________ Provider: __________________________ Result: _______________________

Date of Last Physical/Wellness: _____________________ Provider: _________________ Result: _____________________

Date of Most Recent Pap Test: _________________________ Provider: _________________ Result: _________________

SERIOUS INJURIES: Please list any serious injuries and approximate dates. ______________________________________

____.

OPERATIONS: Please list type and approximate year:

____ ____

____ ____

HOSPITALIZATIONS: (Other than Operations/Surgeries): Please list reason/s and approximate dates:

____

____

SOCIAL / LIFESTYLE:

Type of Residence in which you reside: ________________________________ Do you live with anyone? ______________

If yes, Name and Relationship: ____

Transportation to Appointments Provided By: ____

Last Name: ____________________________ First Name: _____________________________ DOB: _________________

CURRENT MEDICATION LIST

MEDICATIONS: Please list all Prescription AND Over the Counter Supplements below: *(Use other side, if needed)*

Medication Name	Strength/Dose	How Often?	When Started?

I currently take medications to assist symptoms or effects of the following conditions:

- ☐ Anemia Medications
- ☐ Antibiotics
- ☐ Asthma, Wheezing, Shortness of Breath
- ☐ Aspirin, Bufferin, Anacin, Tylenol, or Similar
- ☐ Blood Pressure Pills/Medication
- ☐ Blood Thinners, Coumadin, Warfarin
- ☐ Cortisone, Prednisone
- ☐ Cough Medicine
- ☐ Digitalis, Digoxin, or Heart Medicine
- ☐ Dilantin or Seizure Medications
- ☐ Hormones
- ☐ Insulin or Diabetes Pills
- ☐ Injectable Diabetes Medication (Other)
- ☐ Laxatives, Stool Softeners
- ☐ Phenobarbital/Barbiturates
- ☐ Sleeping Pills/Tranquilizers
- ☐ Thyroid Medication
- ☐ Stomach/Digestive Medicine
- ☐ Vitamins (Prescription and OTC)
- ☐ Water Pills/Diuretics
- ☐ Weight Reducing Medication
- ☐ Other Prescriptions/OTC Medications

ALLERGIES: Are you allergic to any medications? ☐ Yes ☐ No If Yes, Please List Below, with Reaction:

Medication	Reaction	How Treated?

Any OTHER Allergies, not related to Medications? Please list: ____

____

____

Last Name: ______________________________ First Name: _______________________________ DOB: __________________

FAMILY HISTORY:

	AGE	HEALTH	LIVING?	AGE AT DEATH	CAUSE
Father:					
Mother:					
Brother/s:					
Brother/s:					
Sister/s:					
Sister/s:					
Husband/Wife:					
Son/s:					
Daughter/s:					

Check if any blood relative has (or had) any of the following, and enter their relationship to you on the line below:

	YES	NO	RELATIONSHIP		YES	NO	RELATIONSHIP
Arthritis	☐	☐	________________	High Blood Pressure	☐	☐	________________
Asthma	☐	☐	________________	Intestinal Polyps	☐	☐	________________
Bleeding Tendency	☐	☐	________________	Kidney Disease	☐	☐	________________
Cancer	☐	☐	________________	Leukemia	☐	☐	________________
Congenital Heart				Migraines	☐	☐	________________
Disease	☐	☐	________________	Nervous Breakdown	☐	☐	________________
Diabetes	☐	☐	________________	Rheumatic Fever	☐	☐	________________
Emphysema	☐	☐	________________	Sickle Cell Anemia	☐	☐	________________
Epilepsy	☐	☐	________________	Stomach Ulcers	☐	☐	________________
Goiter	☐	☐	________________	Stroke	☐	☐	________________
Gout	☐	☐	________________	Suicide	☐	☐	________________
Hay Fever	☐	☐	________________	Tuberculosis	☐	☐	________________
Heart Attack	☐	☐	________________	Other: _______________	☐	☐	________________

HOME LIFE:

- Do you require assistance to bathe or groom? ☐ Yes ☐ No If Yes: ______________________________________
- Do you require assistance for toilet needs? ☐ Yes ☐ No If Yes: ____
- Do you require assistance to eat or drink? ☐ Yes ☐ No If Yes: ____
- Do you have hearing loss? ☐ Yes ☐ No If Yes, do you wear hearing aids? ☐ Yes ☐ No
- Can you afford all your medications, within reason? ☐ Yes ☐ No Please explain: _________________________
- Do you use any of the following: ☐ Cane ☐ CPAP/BIPAP ☐ Hospital Bed ☐ Walker

  ☐ Wheelchair ☐ Nebulizer ☐ Oxygen (at home) ☐ Oxygen (Portable)